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History Form

Name ______________________________________ **Date of Birth** ________________

Today's Date _____________ **Preferred Name** _______________________ **Age** ______

Please list all **medications and supplements** (prescription and non prescription) that you are taking:

Name of Medication   Strength   Dosage Instructions

____
____
____
____
____
____
____
____
____
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____
____
____
____
____
____
____

What **pharmacy** do you use most often? ______________________________________

Pharmacy Telephone Number ____

Please list all **allergies** to medications:

Allergy   Type of Adverse Reaction (rash,nausea,difficulty brathing, etc.)

____
____
____

Past Medical and Surgical History

Please circle any of the following you have **ever** been diagnosed with and **describe** (year diagnosed, further information, etc.):

Aortic Aneurysm
Alzheimer's Dementia
Anemia
Arthritis
Asthma
Cancer
Cataract
Cerebrovascular accident (stroke)
Cervical Dysplasia (abnormal pap smear)
Cirrhosis of Liver
Colitis
Depression or Anxiety
Diabetes
Edema (swelling)
Emphysema
Endometriosis
GERD (Heartburn/Acid Reflux)
Glaucoma
Gout
Headaches (chronic)
Heart Disease / Heart Attack
HIV
Hypercholesterolemia (high cholesterol)
Hypertension (high blood pressure)
Hyperthyroidism (overactive thyroid)
Hypothyroidism (underactive thyroid)
Kidney Stones
Kidney Failure
Meningitis
Multiple Sclerosis
Osteoporosis
Parkinson's
Peptic Ulcer Disease
Phlebitis or Blood Clots
Rheumatoid Arthritis
Sexually Transmitted Disease
Suicide Attempt
Urinary Incontinence
Urinary Tract Infections (frequent)
Varicose Veins

Other ____

FOR FEMALES:

How many times have you been pregnant? ________________________________

How many vaginal deliveries have you had? ______________________________
(Years)

How many c-sections have you had? ____________________________________
(Years)

How many miscarriages have you had? __________________________________
(Years)

How many abortions have you had? ____________________________________
(Years)

History Form, Continued. **Name**______________________ **Date Of Birth:** ________________

Please list all **surgical procedures** you have **ever** had: **Year**

____

____

____

____

Please list any **other hospitalizations/injuries**: **Year**

____

____

____

Social History

Have you **ever** used **tobacco products** for any significant length of time? YES NO (circle)

If yes, do you currently use tobacco? YES NO (circle)

If yes,

Type of tobacco **used now** ____________________________________

Amount used per day ____

Number of years ____

If no,

Type of tobacco used **in past**__________________________________

Amount used per day in past___________________________________

Number of years used____

When did you stop using tobacco?_______________________________

Alcohol Use: None Minimal Moderate Heavy Previous Heavy User Recovering Alcoholic (circle)

Caffeine Use: Minimal Moderate Heavy (circle)

Exercise: Do you exercise? YES NO (circle)

If yes: Minimally or Regularly (circle)

If regularly, how many times do you exercise per week? _________________________

Type of exercise you perform ____

Are you following a specific type of **diet**? YES NO (circle)

If yes, type ____

Stress Issues: (please circle)

Adult family members at home	Marital difficulty
Alcoholism in family	Out of work
Children in home	Psychiatric illness in family
Domestic violence	Recent death in family
Drug use in family	Recent trauma
Financial difficulty	Stress at work
Illness in family	Other________________________

History Form, Continued. **Name**________________________ **Date Of Birth:** __________________

Have you ever used **recreational drugs**? YES NO (circle)
If yes: Past types used:____
Current types used ____

Do you require **assistance for daily activities**? YES NO (circle)
If yes, type of assistance needed____

Family History

Father:
List illnesses: ____
Still living? YES NO (circle)
If deceased:
Cause of death____
Age at death____

Mother:
List illnesses: ____
Still living? YES NO (circle)
If deceased:
Cause of death____
Age at death____

How many **brothers and sisters** do you have? ____________________________________
What illnesses, if any, do your brothers and sisters have? ____
____
____
____

How many **children** do you have? ____
What illnesses, if any, do your children have? ____
____
____
____

Are you a current patient of a primary care provider? YES NO (circle)
If yes, please list **Name of Physician**:
____
____
____
____

Health Maintenance:

Date of last **Comprehensive Physical Exam** ___________________________________
Date of last **Cholesterol Blood Test** ____

Patient (or Responsible Party)
Signature:______________________________________**Date:**_________________