

# HEALTH HISTORY

NAME \_\_\_\_\_ DATE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

**Please complete all sections.**

Brief description of reason for visit to this office:


Allergies: Medications, Foods, Environmental (ex. Latex)


Social History

Medical and/or Surgical Hospitalization History

Occupation:	
Marital Status:	
Children:	

Do you live alone?      NO      YES

List: Medications, Vitamins and Herbs you are presently taking


**Habits:**

Tobacco	Alcohol	Drugs	Caffeine (type & amount/day) _____
__ Never	__ Never	__ Never	Exercise/Recreation _____
__ Ex	__ Social	__ Social	Seat Belt    __ Yes    __ No
__ Current	__ Ex	__ Ex	Last physical exam _____
_____	_____	_____	Last dental exam _____
Packs/Day	Amount/Day	Type/Frequency	Hours of sleep/night _____

Past Medical History

Have you ever had the following: (Circle "no" or "yes")

Measles	no	yes	Blood Transfusions	no	yes	Bronchitis	no	yes
Mumps	no	yes	Migraine headaches	no	yes	Mitral Valve Prolapse	no	yes
Chickenpox	no	yes	Tuberculosis	no	yes	Stroke	no	yes
Whooping Cough	no	yes	Diabetes	no	yes	Hepatitis	no	yes
Scarlet Fever	no	yes	Cancer	no	yes	Ulcer	no	yes
Diphtheria	no	yes	Polio	no	yes	Kidney Disease	no	yes
Smallpox	no	yes	Glaucoma	no	yes	Thyroid Disease	no	yes
Pneumonia	no	yes	Hernia	no	yes	Bleeding tendency	no	yes
Rheumatic Fever	no	yes	Back trouble	no	yes	Infectious Mono	no	yes
Heart Disease	no	yes	High blood pressure	no	yes	Any other disease	no	yes

