HEALTH INFORMATION

Name: _____ Date: _____ DOB: _____ Age: _____

Hm Phone#: _____ Wk Phone#: _____ Cell#: _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Include your symptoms and when they began: _____

MEDICAL HISTORY

Are you currently having or have had problems with:

	Circle		Describe all Yes responses
Eyes, Glaucoma	No	Yes	_____
Ears, Nose, Throat, Hearing	No	Yes	_____
Dental Problems	No	Yes	_____
Lungs, Breathing, Asthma	No	Yes	_____
Digestion, Ulcers	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Heart Trouble, Heart Attack, Murmurs	No	Yes	_____
Irregular Heart Beat	No	Yes	_____
Infections, TB	No	Yes	_____
Kidney Disease	No	Yes	_____
Bleeding Problems	No	Yes	_____
Blood Clots	No	Yes	_____
Balance Problems, Blackouts	No	Yes	_____
Stroke	No	Yes	_____
Psychological Problems	No	Yes	_____
AIDS/HIV Positive results	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Rheumatoid Arthritis	No	Yes	_____
Polio	No	Yes	_____
Epilepsy/Seizures	No	Yes	_____
Hepatitis/Jaundice	No	Yes	_____
Reflux	No	Yes	_____
Emphysema	No	Yes	_____
Thyroid	No	Yes	_____

Other _____
_____
_____

List any
Surgeries/Hospitalizations: _____
_____
_____
_____

MEDICATIONS

List your medications and herbs and their doses: _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: Are you allergic to any medications: No _____ Yes_____
Please list the medications you are allergic to: _____
_____
_____
_____

SOCIAL HISTORY

Employed (occupation): _____
Student: _____ Retired: _____
Marital Status: _____
Children: No _____ Yes _____ How Many? _____

If necessary is anyone available to care for you at home? No_____ Yes_____

History of substance abuse? No _____ Yes _____ What? _____

Smoke currently? No _____ Yes _____ Packs per day? _____ How many years? _____

Quit smoking? No _____ Yes _____ When? _____

Drink alcohol? No _____ Yes _____ How many drinks per day/week? _____

FAMILY HISTORY

Please list family medical history:

MOTHER: _____ Blood Clots _____Diabetes _____Hypertension _____Rheumatoid Arthritis ____Cancer
_____Heart Disease _____Osteoporosis _____ Stroke/Seizures Other: _____
_____
_____
FATHER: _____Blood Clots _____Diabetes _____Hypertension _____Rheumatoid Arthritis ____ Cancer
_____Heart Disease _____Osteoporosis _____ Stroke/Seizures Other: _____
_____
_____
SIBLINGS: How Many? _____
_____Blood Clots _____Diabetes _____Hypertension _____Rheumatoid Arthritis ____Cancer
_____Heart Disease _____Osteoporosis _____Stroke/Seizures Other: _____
_____
_____
_____
_____

Patient Signature: _____ Date: _____