

HEALTH HISTORY

Today's Date: _____

Full Name: _____ Male / Female Date of Birth: _____

Do you have a designated Healthcare Power of Attorney (POA) to make decisions for you, if the need arises? Y / N

If Yes, POA's name and relationship: _____ Do you have a living will? Y / N

Are you allergic to any medications? Y / N If Yes, please list them: _____

MEDICATIONS you are now taking, including injections, birth control and over-the-counter medications and **WHY** you take them:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

OTHER DOCTORS who you see regularly, and the medical condition for which you see each doctor:

PAST SURGERIES OR HOSPITALIZATIONS, AND DATES: (List below and be sure to include surgeries from childhood)

Month/Year	Type of surgery or reason for hospital stay
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST/CURRENT MEDICAL PROBLEMS: Have you ever had or been treated for any of the problems listed below?

High Blood Pressure	Y / N	Glaucoma	Y / N	Cancer	Y / N
Stroke	Y / N	Depression	Y / N	Anemia	Y / N
Heart Attack or Angina	Y / N	Allergies	Y / N	Heart Murmur	Y / N
Fracture of a major bone	Y / N	Acid Reflux	Y / N	High Cholesterol	Y / N
Blood Clots or Bleeding Problem	Y / N	Ulcers	Y / N	Asthma	Y / N
Kidney or Urinary Stones	Y / N	Seizures	Y / N	Alcohol/Drug Addiction	Y / N
Disc Disease of neck/lower back	Y / N	Arthritis	Y / N	Diabetes	Y / N

Write in any other problems not listed above:

Year of last tetanus shot: _____ Year of last pneumonia shot: _____ Year of varicella (chicken pox) shot: _____
or varicella (chicken pox) disease: _____

SOCIAL HISTORY:

Marital Status: Single / Married / Divorced / Widowed Job or Profession: _____

Number of children you've had: _____ Number of adopted or step children: _____

Have you ever used tobacco (circle one)? Never / In the Past / Currently Total number of years of lifetime tobacco use: _____

Type and amount of tobacco currently used per day: _____

Do you drink any alcohol (circle one)? Never / In the Past / Currently Average amount per month: _____

Do you use any illicit or recreational drugs (circle one)? Never / In the Past / Currently

FAMILY HISTORY:

Have any of your BLOOD RELATIVES had any of the following conditions? If so, indicate relationship (grandparent, etc.)

Condition / Family member(s):	Condition / Family member(s):
Asthma _____	Diabetes _____
Glaucoma _____	Cancer (state type) _____
Epilepsy _____	Blood Diseases _____
Rheumatoid Arthritis _____	Tuberculosis _____
High Blood Pressure _____	Mental Illness _____
Stroke _____	Osteoporosis _____
Heart disease (heart attack, angina, or cardiac bypass surgery): _____	