

Patient Health History

Name: _____ Birth Date: _____ Today's Date ____/____/____

Occupation: _____

Present Concerns:

Past History

I. Surgeries (with dates)

- A. _____
 B. _____
 C. _____

II. Hospitalizations (with dates)

- A. _____
 B. _____
 C. _____

III. Other Illnesses (with dates)

- A. _____
 B. _____
 C. _____
 D. _____
 E. _____

Medications

<u>Name</u>	<u>Dosage</u>	<u>Per Day</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

<u>Medication</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____

Family History- Please indicate any significant illnesses in the following family members:

	Father	Mother	Grandparents	Aunts	Uncles	Children
Heart Disease						
Hypertension						
Diabetes						
High Cholesterol						
Lung Cancer						
Breast Cancer						
Colon Cancer						
Prostate Cancer						
Other Cancers						
Other Diseases						

Social History

	Never	Current	Packs/Year
Smoking			

	Drinks/Week
Alcohol	

	General	Low Carb	Low Fat	Vegetarian	Other
Diet					

	Activity	Times/Week	Duration
Exercise			

