HEALTH HISTORY

FULL NAME _____ AGE _____ DATE _____

REFERRING PHYSICIAN _____ ADDRESS _____

Why are you coming to the doctor? _____

_____

PAST ILLNESSES OR PROBLEMS

Check if you have had the following:

DISEASE	DATE	DISEASE	DATE	DISEASE	DATE
Measles	_____	Heart Disease/Murmur	_____	Polyps (nose or colon)	_____
Mumps	_____	High Blood Pressure	_____	Eye/Glaucoma	_____
Chickenpox	_____	Rheumatic Fever	_____	Mental Disease	_____
Whooping Cough	_____	Emphysema	_____	Epilepsy (seizures)	_____
Diphtheria	_____	Pneumonia	_____	Nervous Exhaustion	_____
Scarlet Fever	_____	Tuberculosis	_____	Neuritis/Sciatica	_____
Polio	_____	Bronchitis	_____	Depression	_____
Mononucleosis	_____	Asthma/Hay Fever	_____		
Typhoid Fever	_____	Stomach Ulcers	_____	OTHER (specify):	_____
Malaria	_____	Rectal Bleeding	_____	_____	
Venereal Disease	_____	Vomiting Blood	_____	_____	
Shingles	_____	Liver Disease/		_____	
Anemia/B12 Deficiency	_____	Hepatitis (jaundice)	_____		
Cancer/Leukemia	_____	Pancreatitis	_____		
Diabetes	_____	Hernia (Hiatal or Other)	_____		
Thyroid/Goiter	_____	Heartburn	_____		
Cholesterol/Lipid	_____	Hemorrhoids	_____		
Gout	_____	Kidney/Bladder	_____		
Rheumatism/Arthritis	_____	Prostate	_____		
Bursitis	_____	Abnormal Pap Smear	_____		

OPERATIONS

Check if you have had any of the following procedures:

SURGERY	DATE	SURGERY	DATE	SURGERY	DATE
Cataract/eye	_____	Moles/Skin cancer	_____	Prostate	_____
Tonsillectomy	_____	Cancer	_____	D&C	_____
Nose/sinus	_____	Appendectomy	_____	Abortion	_____
Thyroid	_____	Varicose Veins	_____	Tubes Tied	_____
Breast	_____	Hernia Repair	_____	Hysterectomy	_____
Lung	_____	Gallbladder	_____	Vasectomy	_____
Heart/Valve	_____	Ulcer	_____	OTHER (specify):	_____
Ruptured Disc	_____	Colon (bowel)	_____	_____	
Broken Bones	_____	Hemorrhoidectomy	_____	_____	

List below any significant injuries or accidents you may have had and include the dates:

_____

_____

HOSPITALIZATIONS

State below any hospitalizations not included in the above information:

General: _____ Mental: _____

_____ _____

PREGNANCY HISTORY: Number _____ Birth weights _____ Abortions/Miscarriages _____

Complications _____ High Blood Pressure _____ Toxemia _____ Sugar _____

Current method of birth control _____

~ continued on back ~

SPECIAL STUDIES

Check any of the special studies below that you have had:

STUDY	DATE	STUDY	DATE	STUDY	DATE
Chest X-ray	_____	Skull X-ray	_____	TB Skin Test	_____
Stomach X-ray	_____	Breast (mammogram)	_____	CT Head	_____
Colon X-ray	_____	Proctoscope	_____	Body Scan	_____
Kidney X-ray	_____	EEG	_____	Others (specify):	_____
Bladder X-ray	_____	EKG	_____	_____	

MEDICATIONS

Allergies to medicines:

DRUG	REACTION
_____	_____
_____	_____
_____	_____

Medications now taking:

_____
_____
_____
_____

IMMUNIZATIONS

Check if you have had any of the following:

	DATE		DATE		
Smallpox	_____	Mumps	_____	OTHERS (specify):	____
Typhoid	_____	Pneumovax	_____	_____	
Influenza (flu shot)	_____	Measles (Rubeola)		_____	
Polio	_____	(Rubella-German)	_____	_____	
Tetanus	_____	Diphtheria	_____	_____	

PERSONAL HISTORY

How long married? _____ Spouse's age _____ Married how many times _____
Spouse's health _____ Widow/Widower _____ How long widowed? _____
Cause of spouses death _____
Number of children _____ Ages _____ Sexes _____
Alcohol Intake _____ Tobacco _____ packs/day How long used? _____
Coffee/Tea _____ cups/day Sleep _____ hours/day
Recreation _____ Hobbies _____ Vacations _____
Most vigorous activity _____

SOCIAL HISTORY

Education _____
Occupation: Present _____ Past _____
Previous Residence _____
Church Attendance _____
Military Service _____ Where? _____

FAMILY HISTORY

MEMBER	LIVING	DECEASED	AGE	HEALTH OR CAUSE OF DEATH
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sisters (total #)	_____	_____	_____	_____
Brothers (total #)	_____	_____	_____	_____

Check if any family member has had any of the following:

Allergies or Asthma	_____	Glaucoma	_____	Obesity	_____
Anemia	_____	Gout	_____	Rheumatism/	
Bleeding/Blood disorder	_____	Heart Trouble	_____	Arthritis	_____
Diabetes	_____	High Blood Pressure	_____	Suicide	_____
Cancer or Tumors	_____	Kidney/Bladder	_____	Tuberculosis	_____
Epilepsy/Seizures	_____	Nervous/Mental	_____	Ulcers	_____
Hay Fever	_____	Eczema	_____	Colitis	_____

Please state any pertinent medical problems that are not included elsewhere on this sheet: _____

_____