

Health History
 (Confidential)

Name _____ Age of patient _____ Date of Visit _____

PERSONAL HISTORY

Birthplace _____ Birthdate _____
 Education _____ Marital Status _____
 Health of Spouse _____
 Sleep (usual hours) _____ Aids to sleep _____
 Recreation _____
 Exercise _____
 Religion _____

MEDICINES TAKEN REGULARLY

| Name | Dose | Reason |
|------|------|--------|
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PERSONAL FAMILY HEALTH HISTORY

Check (✓) if you or your blood relatives have or have had any of the following:

| You | Disease | Family | Relation to |
|-----|----------------------|--------|-------------|
| | AIDS, HIV positive | | |
| | Alcohol dependency | | |
| | Allergies, hayfever | | |
| | Anemia | | |
| | Arthritis, gout | | |
| | Asthma | | |
| | Bleeding tendency | | |
| | Cancer | | |
| | Chronic lung disease | | |
| | Convulsive disorder | | |
| | Diabetes | | |
| | Drug dependency | | |
| | Heart disease | | |
| | High blood pressure | | |
| | Kidney disease | | |
| | Leukemia | | |
| | Mental illness | | |
| | Migraines | | |
| | Obesity | | |
| | Peptic ulcer | | |
| | Stroke | | |
| | Thyroid trouble | | |
| | Tuberculosis | | |
| | Other | | |

ALLERGIES & SENSITIVITIES

List all substances, including drugs, to which you have had an adverse reaction

| Substance | Describe reaction |
|-----------|-------------------|
| | |
| | |
| | |
| | |

OCCUPATIONAL CONCERNS

Your occupation _____

Check (✓) if your works exposes you to the following:

| ✓ | Exposure | Describe |
|---|---------------|----------|
| | Hazardous | |
| | Heavy lifting | |
| | Stress | |
| | Other | |

HEALTH HABITS

Describe how much of each of these substances you use:

Caffine _____

Tobacco _____

Alcohol _____

Other _____

Circle "Yes" or "No"

| | | |
|---|-----|----|
| Have you ever felt you should cut down on your drinking? | Yes | No |
| Have people annoyed you by criticizing your drinking? | Yes | No |
| Have you ever felt bad or guilty about your drinking? | Yes | No |
| Have you ever had a drink first thing in the morning to calm your nerves or get rid of a hang-over? | Yes | No |

HOSPITALIZATIONS & SURGERIES

| Year | Hospital | Reason for hospitalization |
|------|----------|----------------------------|
| | | |
| | | |
| | | |
| | | |

Have you ever had a blood transfusion? _____

If yes, please give approximate dates: _____