

PATIENT HEALTH HISTORY

PATIENT NAME: _____ AGE: _____

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Primary Care Doctor: _____

Smoking (type & amount per day) _____ Alcohol (type & amount per week) _____

If former smoker, date quit: _____ Weight _____ Height _____

Drug allergies and reactions: _____

List previous surgeries or major illnesses and dates: _____

List any medications you are taking, including non-prescription, vitamins and herbals: _____

Family History:

Has any blood relative ever had the following? (check all that apply):

Table with 4 columns and 3 rows listing medical conditions: Breast Cancer, High Blood Pressure, Kidney Disease, Melanoma, Heart Disease, Depression, Stroke, Diabetes.

Past Medical History:

Have you ever had the following?: (check all that apply)

Table with 4 columns and 7 rows listing medical conditions: Heart Disease, Cancer, Stomach Ulcer, Arthritis, Glaucoma, Kidney Disease, Rheumatic Fever, Asthma, Thyroid Disease, Anemia, AIDS or HIV+, Bleeding Tendency, Tuberculosis, Stroke, Mitral Valve Prolapse, Diabetes, Hepatitis, High Blood Pressure.

Review of Symptoms:

Do you have or have you had within the past year: (check all that apply)

Table with 4 columns and 6 rows listing symptoms: Weight Changes, Swollen feet/ankles, Seizures, Dry Eyes, Skin Rash, Joint/Muscle Pain, Chronic Cough, Chronic Diarrhea, Swollen Lymph Nodes, Chest Pain, Jaundice, Easy Bleeding, Rapid Heart Beat, Depression, Easy Bruising.

Women Only:

Date of last mammogram _____

Do you do regular breast self-exams? ___Yes___No

Have you had a breast lump or discharge? ___Yes___No

Did you breast feed? ___Yes___No

Bra size _____

Have you had/or plan to have any:

Chemotherapy ___Yes___No

Radiation ___Yes___No

Date of last Treatment _____

I verify that the above information is true and accurate to the best of my knowledge.

X _____ Signature of Patient or Parent if Minor

_____ Date