HEALTH HISTORY

Patient Name ____ Age __________

Last First

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

Primary Care Doctor ____

Nicotine (type and amount per day)______________________ Alcohol (type and amount per week) ___________________

If former nicotine use, date quit _______________________ Height ________________ Weight ______________________

Drug allergies and reactions ____

____

List previous surgeries or major illnesses and dates ____

____

List current medications (including non-prescription) vitamins and herbals ________________________________

____

FAMILY HISTORY

Has any blood relative had the following? (circle all that apply)

Breast Cancer	High Blood Pressure	Kidney Disease	Stroke
Melanoma	Heart Disease	Depression	Diabetes

PAST MEDICAL HISTORY

Have you had any of the following? (circle all that apply)

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	High Blood Pressure
Diabetes	Hepatitis	Other:	

REVIEW OF SYMPTOMS

Do you have or have you had within the past year? (circle all that apply)

Weight Change	Swollen Feet/ Ankles	Seizures	Dry Eyes
Chronic Diarrhea	Joint/ Muscle Pain	Chronic Cough	Skin Rash
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

Have you breast fed? Yes No

Bra size ______________

Have you had/ plan to have

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