

Health History

Name: _____ Today's Date: _____

Date of Birth: _____

PROBLEMS								
Active	Past		Active	Past		Active	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Measles
<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Prostate	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Fecal Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Numbness:
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Pain:
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Polio
<input type="checkbox"/>	<input type="checkbox"/>	Breast Lump	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis:	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Herpes:	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Constipation (chronic)	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid Fever
<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid (high)	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid (low)	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease:
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea (chronic)	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____								

SURGICAL/HOSPITALIZATION HISTORY			PREGNANCY HISTORY		
Description	Year	Reason	Year	Sex	Complications

FAMILY HISTORY

Relation	Age	State of Health	Age at Death	Cause of Death	Relatives with the following conditions	
					Disease	Relationship
Father					<input type="checkbox"/>	Arthritis
Mother					<input type="checkbox"/>	Asthma
Brothers					<input type="checkbox"/>	Cancer
					<input type="checkbox"/>	Depression
					<input type="checkbox"/>	Diabetes
					<input type="checkbox"/>	Heart Disease
Sisters					<input type="checkbox"/>	Hypertension
					<input type="checkbox"/>	Kidney Disease
					<input type="checkbox"/>	Other:
					<input type="checkbox"/>	

SOCIAL HISTORY

Current	Past	Frequency	Description & Frequency
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use	
<input type="checkbox"/>	<input type="checkbox"/>	Drug Use	
<input type="checkbox"/>	<input type="checkbox"/>	Caffeine	
<input type="checkbox"/>	<input type="checkbox"/>	Exercise	
<input type="checkbox"/>	<input type="checkbox"/>	High Risk Sexual Behavior	
<input type="checkbox"/>	<input type="checkbox"/>	Other:	

Marital Status

Single
 Married
 Separated
 Divorced
 Widowed
 Other

Sexual Orientation

Heterosexual
 Homosexual
 Bisexual
 Other:

ALLERGIES

No known allergies

Substance	Reaction

MEDICATIONS

No current medications

Name of Medication	Dose

PREVENTIVE CARE

Procedure	Date	Immunization	Date
Colonoscopy		Influenza	
Eye Exam		Pneumococcal	
Mammogram		Tetanus	
PAP Smear			
Physical			
Prostate Exam			