PATIENT HEALTH HISTORY

LAST NAME: _____ FIRST NAME: _____ MI: ____ SUFFIX: ____

M: _____ F: _____ AGE: _____ DOB: _____ HEIGHT: _____ WEIGHT: _____

PRIMARY CARE PHYSICIAN: _____

CARDIOLOGIST: _____ OTHER SPECIALIST: _____

MEDICAL ILLNESS

_____ Aids / HIV	_____ Blood Clots	_____ Endocrine	_____ Hypertension	_____ Seizures
_____ Anemia	_____ Cancer	_____ GI	_____ Lung Disease	_____ Stroke
_____ Asthma	_____ Cardiac Disease	_____ Hepatitis	_____ Osteoporosis	_____ Ulcer
_____ Bleeding	_____ Diabetes	_____ High Cholesterol	_____Renal	_____ Urinary

Other Medical Conditions: _____

SURGERIES / HOSPITIALIZATION / YEAR

_____

_____

MEDICATION / DOSAGE / ROUTE (oral, injection, topical, etc.)

_____

_____

Allergies / Reaction: _____

SOCIAL HISTORY

Occupation: _____ Marital Status: Single___ Married___ Divorced___ Widowed___

Do you have children: _____ Yes _____ No Do you live alone: _____ Yes _____ No

Do you smoke: ____ Yes ____ No * If yes, how many packs per day _____ for _____ years.

Do you drink alcohol: ____ Yes ____ No * If yes, average amount per week: _____

Exercise: ___ Yes ___ No _____ Daily _____ Weekly _____Rarely

FAMILY HISTORY

Member	Alive	Age	Deceased	Pertinent Health Issues	Cause of Death
Father	**A**		**D**		
Mother	**A**		**D**		
Siblings	**A**		**D**		

I certify that to the best of my knowledge, the information above is true and complete.

Patient Signature: _____ Date: _____