HEALTH

FAMILY CARE

Health History Form

Patient Name: ______________________________ Date of Birth: ______________

Date of Last Wellness Exam/Physical: ______________________

Primary Care Physician: ______________________________

List any hospitalizations and dates: ***Continue list on back if needed.****

Date	Reason	Date	Reason

Current Health Problems	Date of Onset
1.	
2.	
3.	
4.	
5.	

****Continue list on back if needed.****

Surgical History – ex. Knee replacement	Date of Surgery

****Continue list on back if needed.****

CURRENT MEDICATIONS (Include vitamins and over the counter medications)	**DOSAGE**	**HOW MANY TIMES PER DAY**
EX: Aspirin	*81 mg*	*Once a day*

****Continue list on back if needed.****

Are you **allergic** to any **medications?** Yes No If yes, please list: ______________________________

Environmental/Food allergies? Yes No If yes, please list: ______________________________

Do you have a living will or advanced directives? Yes No If yes, please provide a copy to our office

HEALTH

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FAMILY HISTORY ****Continue list on back if needed.****

Relative	***Age***	***Medical Conditions***	***Age of Death***	***Cause of Death***
Father				
Mother				
Sibling				
Sibling				
Child				
Child				

Do you **Smoke?** Yes No If yes, how many per day? ____________________
Did you ever **Smoke?** Yes No If yes, when did you stop? ____________________
Do you **Drink Alcohol?** Yes No If yes, how many drinks a day? ________________
Did you ever **Drink Alcohol?** Yes No If yes, when did you stop? ____________________

Have you ever had any of the following tests performed:
Colonoscopy Yes No If Yes, when? __________________
Pap Smear Yes No If Yes, when? __________________
Mammogram Yes No If Yes, when? __________________
Bone Density Scan Yes No If Yes, when? __________________
Pneumonia Vaccine Yes No If Yes, when? __________________
Tetanus Booster Yes No If Yes, when? __________________

OTHER PHYSICIANS:
OB/GYN: ____ City/State: _____________________________

NEURO: ____ City/State: _____________________________

CARDIOLOGIST: ____ City/State: _____________________________

PULMONOLOGIST: _______________________________________ City/State: _____________________________

ORTHOPEDIC: ____ City/State: _____________________________