PT.#_____

HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE _____

Please complete entire form. This is a confidential record of your medical history and will be kept in this office.

Date _____
Place of birth _____
Highest level in school _____
Occupation _____
Marital Status _____
Hobbies _____
Exercise _____
List all allergies (food, drugs, environment)
_____
_____

Smoking (type & amt per day) _____
If quit, when? _____
Alcohol (type & amt per wk) _____
Caffeine (type & amt per day) _____
Street drugs (type & amt) _____
Usual weight _____
Date of last dental exam _____
Date of last physical exam _____
Date of last chest x-ray _____

PAST MEDICAL HISTORY

List all serious illnesses, operations, and other hospitalizations and year these occurred: NONE _____

_____
_____
_____

Circle any of the following you have ever had. Leave blank if uncertain.

Measles	Pneumonia	Glaucoma	Bleeding tendency	Venereal Disease
Smallpox	Bladder Infection	Hemorrhoids	Scarlet Fever	Diabetes
Anemia	Polio	Mitral Valve Prolapse	Arthritis	Back Trouble
Cancer	Bronchitis	Whooping Cough	Tuberculosis	Aids or HIV+
High/Low Blood Pressure	Thyroid Disease	Migraines	Blood transfusion	Ulcer
Infectious Mono	Chickenpox	Hernia	Hives or Eczema	
Kidney Disease	Rheumatic Fever	Asthma	Hepatitis	
Mumps	Epilepsy	Stroke	Diptheria	

FAMILY HISTORY

Has any blood relative had any of the following: Circle any that apply and give relationship. Leave blank if uncertain.

	Relationship		Relationship		Relationship
Cancer	_____	Anemia	_____	Obesity	_____
Tuberculosis	_____	Bleeding tendency	_____	Thyroid Disease	_____
Diabetes	_____	Asthma	_____	Ulcer	_____
Heart Disease	_____	Lung Disease	_____	Depression	_____
High blood pressure	_____	Drug or alcohol problem	_____	High Cholosterol	_____
Stroke	_____	Mental Illness	_____	Kidney Disease	_____
Epilepsy	_____	Leukemia	_____	Glaucoma	_____
Allergies	_____	Migraines	_____	Gout	_____

Present age or age of death. If living, health (good, fair, poor). If deceased, cause of death.

Father _____ Mother _____
Siblings _____ Spouse _____
_____ Children _____
_____ _____

To the best of my knowledge, the questions on this form have been accurately answered. I authorize the healthcare staff to perform the necessary health care services I (my child) may need.

_____ Signature of patient or parent _____ Date