ESSENTIAL Family Medicine

Health History

Name: _____ **DOB**: _____ **Age**: _____

Do you have any allergies? Yes or No If so, list: _____

Do you smoke? Yes or No If so, how many packs per day? _____

Drink Alcohol? Yes or No If so, how often? _____

Use Recreational Drugs? Yes or No

Current Medications- Please List Name & Dosage:

_____

_____

Known Health Problems:

_____

_____

Previous Surgeries:

_____

_____

Any family history of:

Breast cancer:	Yes	or	No	IF Yes, Relation: _____
Colon cancer:	Yes	or	No	_____
Uterine cancer:	Yes	or	No	_____
Ovarian cancer:	Yes	or	No	_____
Osteoporosis:	Yes	or	No	_____
Heart Disease:	Yes	or	No	_____

Current Physicians Seen:

_____ _____ _____