HEALTH HISTORY AND CONSENT FORM

Do you have a living will? Yes No

NAME: (Last, First, Middle)_____**Birth Date:**_____

HABITS: 1.Do you smoke?_____ If yes, how much?_____ How many years?_____ If quit, when?_____
2. Do you drink alcohol?_____ If yes, how much? _____If quit, when?_____
3. List other habits if any_____

OCCUPATION: Current:_____ Past Occupations:_____

LIST all your **MEDICATIONS**: (Include birth control pill/injection, inhalers, vitamins etc)__
_____
_____

LIST all your **DRUG ALLERGIES:**_____
_____

PREVIOUS SURGERIES AND HOSPITALIZATIONS:_____
_____
_____

PREVIOUS MAJOR INJURIES/ACCIDENTS:_____

Immunization --- Month/year	
Please provide proof/document.	
***Tetanus*(*Td*)**	
Pneumonia	
Last Flu shot	
MMR	
Varicella	
Hepatitis B	
Other	

PREVIOUS/CHRONIC ILLNESSES: (Check each item Yes or No; If yes, write "**C"**if the problem still exists)

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Arthritis			High B.P			Liver Disease			Measles		
Anemia			Heart attack (MI)			Kidney Disease			Meningitis		
Bleeding disorder			Heart disease			Urinary Stones			Mononucleosis		
Allergies/Hay fever			Stroke			Diabetes			Pneumonia		
Asthma			Seizure/Epilepsy			Thyroid Disease			Tuberculosis		
Emphysema/COPD			Hepatitis			Chicken Pox			Cancer of		

DISABILITIES (including learning disability) **& OTHER ILLNESSES** not listed above:_____
_____
_____

FAMILY HISTORY: Among your blood relatives, did any one has/had the following? (check appropriate boxes)

Family History of	Yes	No	If yes, who has/had it?	Family History of	Yes	No	If yes, who has/had it?
Asthma				Tuberculosis			
Diabetes				Mental Disease			
High Blood Pressure				Breast Cancer			
Heart Attack				Cervical Cancer			
Heart Disease (other)				Colon Cancer			
Stroke				Prostate Cancer			
Seizures/Epilepsy				Other			

HIPPA COMPLIANCE: By my signature below, I acknowledge the receipt of &/or have read the Notice of Privacy Practices (NPP) which describes in detail how your health information may be used and disclosed, and how you can access this information**.** (Ask for a copy of privacy Notice if you did not see or receive one)

CONSENT: I hereby authorize Allcare Medical clinic & its provider(s) to perform the necessary exams/procedures for the health assessment and treatment of myself and/or my children, and to furnish the resulting health information to appropriate parties.

SIGNATURE:_____ Relationship with patient_____ DATE_____