KAREWELL MD PATIENT CARE

CHABOT FAMILY ASSOCIATES, INC.
19845 LAKE CHABOT RD, #205
CASTRO VALLEY, CA, 94546
PH: 510-582-6424 FAX: 510-582-6462

HEALTH HISTORY

Personal Information Date:_____

Patient Name: _____ Birth Date: _____ Age: ____
Occupation _____ Marital Status: _____ SEX : _____
Name of Partner/Spouse: _____
Number of children: _____
Children's Names/Age : _____
_____

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor:

_____

_____

_____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): _____

Preferred **Pharmacy(Name / Address)** _____

_____

Date of Last Complete Physical Exam: _____ Date of Last Blood Work: _____

For Females: Date of Last Menstrual Period: _____ Date of Last Pap Smear: _____

History of Abnormal Pap (list date/s)? _____

Number of Pregnancies: _____ No of Miscarriages: _____ No of Terminations: _____

Method/s of Contraception: _____

Continued …..

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If **YOU** or a **FAMILY MEMBER** has had any of the following, please select and indicate which family member when applicable:

CONDITION	DETAILS	WHO HAD THE CONDITION
☐ ADD / ADHD		
☐ Allergies / Hay Fever		
☐ Arthritis		
☐ Alcoholism		
☐ Anemia		
☐ Anxiety/Depression		
☐ Bone Problems		
☐ Blood Problems		
☐ Cancer		
☐ Diabetes Type 1 or 2		
☐ Fractures		
☐ Gynecological Disease		
☐ High Cholesterol		
☐ High Blood Pressure		
☐ Heart Problems		
☐ Kidney Disease		
☐ Liver Disease		
☐ Neurological Disease		
☐ Respiratory Disease		
☐ Skin Disease		
☐ Stomach / Colon Disease		
☐ Stroke		
☐ Seizure Disorder		
☐ Sexually Transmitted Disease (STD)		
☐ Thyroid Disorder		
☐ Modd Problems		

Continued …..

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Please list any **SURGERIES** you have had and include the month/year:

_____

_____

_____

_____

Social Information

Tobacco Use: Do you smoke? _____

How many cigarettes/cigars per day: _____

No. of years smoking: _____

Do you chew tobacco? _____

Alcohol Use: Do you drink alcohol? _____

If so, what type? _____

How many in 1 week? _____

Drug Use: Any history of drug use? _____

If so, what type/s? _____

When? _____

Do you **exercise**? _____

What activities do you do, and how often in ONE week ? _____

Are you on any special **diet**? _____

If so, what? _____

Do you consume any **caffeinated** products? _____

If so, what and how much per day? _____

Do you have an Advanced Directive? _____ If yes, please provide us a copy.

Please provide any addition information which you would like to be addressed during your visit:

_____

_____

_____

_____

_____

_____

_____

_____

_____