CHABOT FAMILY ASSOCIATES, INC.
19845 LAKE CHABOT ROAD, #205 CASTRO VALLEY, CA, 94546
2324 SANTA RITA RD, SUITE 8 PLEASANTON , CA, 94566
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:

____

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TOTAL NO OF PAGES = 3