Updated 11/7/2023

# General Health History

Last Name: _____ First Name: _____Middle: _____

## Personal Medical History:

| | | | |
|---|---|---|---|
| **Ear/Nose/Throat:** hard of hearing, stuffy nose, earache, cough dry mouth, etc. | Yes | No | Comments: |
| **Heart (cardiovascular):** high blood pressure, elevated heart rate, chest pain, Afib, etc. | Yes | No | Comments: |
| **Lungs (respiratory):** congestion, wheezing, shortness of breath, cough, asthma etc. | Yes | No | Comments: |
| **Digestion (gastrointestinal):** upset stomach, acid reflex, diarrhea, constipation, ulcers, cramps etc. | Yes | No | Comments: |
| **Muscles and bones (musculoskeletal):** pain/spasms, joint pain or swelling, stiffness, etc. | Yes | No | Comments: |
| **Urological:** frequent urination, pain with urination, burning, incontinence, infections | Yes | No | Comments: |
| **Gynecological:** pregnancies, ovarian or uterine conditions, menstrual problems etc. | Yes | No | Comments: |
| **Breast:** cysts, fibroids, pain, numbness, etc. | Yes | No | Comments: |
| **Neurological:** numbness, weakness, headaches, seizures, tremors, tingling etc. | Yes | No | Comments: |
| **Psychiatric**: depression, anxiety, mood swings, insomnia, hallucinations etc. | Yes | No | Comments: |
| **Lymphatic**: high cholesterol, anemia, blood disorders, bleeding, clotting issues | Yes | No | Comments: |
| **Skin**: itching, rash, cancer, infections, warts or growths etc. | Yes | No | Comments: |
| **Cancer** | Yes | No | Type: |
| **Allergies**: environmental, medications, hives | Yes | No | Comments: |
| **Hormones (Endocrine**): Diabetes, thyroid, fatigue, hair loss, hot or cold intolerance | Yes | No | Comments: |
| **Major Illness/ Hospitalizations** | Yes | No | Please provide dates of hospitalizations: |
| **Surgeries** | Yes | No | Comments: |
| **Other** | Comments: | | |

## Social History

Marital Status: _____ Living Situation: _____ Occupation: _____

Tobacco Use: circle one

| | | | | | |
|---|---|---|---|---|---|
| Never | Current everyday use | Current intermittent use | Former Use | Unknown | Other |

Alcohol Use: circle one

| | | | | | |
|---|---|---|---|---|---|
| Never | Current everyday use | Current intermittent use | Former Use | Unknown | Other |

Recreational Drug Use (MMJ): circle one

| | | | | | |
|---|---|---|---|---|---|
| Never | Current everyday use | Current intermittent use | Former Use | Unknown | Other |

Do you wear your seat belt? YES NO

Updated 11/7/2023

**Medications**

| Medication Name | Dose | Frequency | Additional Info |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

If medication list goes beyond the space provided, please attach a separate sheet

**Allergies**

| Allergy<br>(Please list both environmental and medication allergies) | Severity<br>(mild, moderate, severe) | Reaction<br>(hives, anaphylaxis, rash, GI upset) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Preferred Pharmacy**

| Name | Address | Phone Number | Fax Number |
|---|---|---|---|
| | | | |
| Please note if your preferred pharmacy is a mail order pharmacy, provide a local pharmacy for urgent prescriptions below: | | | |
| Name | Address | Phone Number | Fax Number |
| | | | |

**Specialists**

| Doctors Name | Office Information | Disease Managed | Additional Information |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Signature: _____ Date: _____

Printed Name: _____