Health History Form

Name _____ Date_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

Email _____

Date of Birth _____ Sex: M/F Height____ Weight_____

For the following questions, circle yes or no.

1. Has there been a change in your health in the past year? Y N
2. When was your last physical exam? Y N
3. Have you had any serious illness, operation, hospitalization? Y N
   If yes, please describe _____
   _____
4. Are you taking any medications? Y N
   If yes, please list _____
   _____
5. Do you have any of the following?
   - Heart trouble Y N
   - Asthma, allergies Y N
   - Fainting spells or seizures Y N
   - Diabetes Y N
   - Liver trouble Y N
   - Thyroid problems Y N
   - Respiratory problems Y N
   - Arthritis Y N
   - Kidney disease Y N

Health History Form (continued)

6. Do you have any other condition or disease the doctor should know about? If yes, please describe _____ Y N

_____

7. Do you smoke? Y N

If yes, how much per day _____

8. How much alcohol do you drink per week?_____

9. Are there any problems at home, work or school you would like to discuss? Y N

Patient's Signature _____