Health History

Patient Name: ______________________________________ Date of Birth: ____/____/____ Date: _____________

Personal History: Within last 5 years (Check all that apply) If yes please give dates:

Alcohol Trouble	❑	Epilepsy	❑	Kidney Trouble	❑	Sexual Diseases	❑
Anxiety	❑	Fainting Spells	❑	Lung/Respiratory Disease	❑	Stroke	❑
Asthma	❑	Glaucoma	❑	Measles	❑	Thyroid Issues	❑
Back Trouble	❑	Headaches	❑	Memory Loss	❑	Tuberculosis (T.B.)	❑
Bleeding Disorder	❑	Heart Disease	❑	Mental Illness	❑	Ulcer	❑
Cancer	❑	Heart Murmur	❑	Migraine	❑	Urinary Tract Infection	❑
Chicken Pox	❑	Hepatitis	❑	Mononucleosis	❑	Whooping Cough	❑
Chronic Pain	❑	Hernia	❑	Mumps	❑		
Depression	❑	High Blood Pressure	❑	Polio	❑		
Diabetes	❑	High Cholesterol	❑	Rheumatic Fever	❑		

Other Chronic Illnesses:

____

Surgeries (including accidents/fractures) & Dates: ____

Habits (Check all that apply and specify how much)

Tobacco ❑__________ Alcohol ❑__________ Drugs ❑___________ Caffeine ❑__________ Exercise❑____________

Date of Previous Screening Tests (If applicable)

Pap Smear: _____________ Mammogram: ____________ Bone Density: ____________ Colonoscopy: _______________

Immunization Dates (If applicable) Pneumococcal: _______________ Flu: ______________ Tetanus: ____________

Allergies to Medications or Other Substances (please Describe) ____

____

Current Medications (list by name, dose, and frequency. Including over the counter): ___________________________

____

Family History (Check all that apply and specify what 1st degree relative-parents, grandparents, siblings, Aunt. Uncle:(Alive, Well, or Deceased)

Alcoholism	❑	High Cholesterol	❑
Bleeding Disorder	❑	Kidney Disease	❑
Cancer	❑	Mental Health	❑
Depression	❑	Seizure Disorder	❑
Diabetes	❑	Stroke	❑
Heart Disease	❑	Thyroid Disorder	❑
High Blood Pressure	❑		

Other Family History:

ACHC
ADAMS COUNTY HEALTH CENTER INC.
Working Together to Improve Lives in Our Communities