Print Form

NORTH ISLAND MEDICAL
HEALTH HISTORY FORM

Name: _____ Date: _____

Reason for Visit:_____

Allergies/Sensitivities:_____

Past Surgeries: _____

PAST MEDICAL HISTORY: **Check if you've been treated for in the past**

☐ High Blood Pressure	☐ High Cholesterol	☐ Liver Disease	☐ Diabetes
☐ Thyroid Problems	☐ Kidney Disease	☐ Heart Disease	☐ Stroke
☐ Seizures/Epilepsy	☐ Reflux Disease	☐ Arthritis	☐ Cancer
☐ Stomach Problems	☐ Intestinal Problems	☐ Abnormal PAP	☐ Glaucoma
☐ Kidney Stones	☐ Tuberculosis	☐ Prostate Disease	☐ Pneumonia
☐ Osteoporosis	☐ Blood Clots	☐ Hepatitis	☐ HIV
☐ Psychological Issues	☐ Ear/Sinus Issues	☐ Asthma	☐ Fainting
☐ Menstrual Problems	☐ Sickle Cell Disease		

Other Concerns:_____

_____

Family History of Serious Illness:_____

Occupation _____ Hobbies/Interests _____

Alcohol Use _____ Tobacco Use _____

Transportation/Housing Difficulties _____ Difficulty preparing meals _____

Do You Exercise? ☐ How often? _____

Immunizations: ☐ Shingles ☐ Pneumonia ☐ Flu ☐ Tetanus/Whooping Cough

Tests you've had: ☐ Colonoscopy ☐ Fecal Blood Testing ☐ Mammogram
☐ Pap Smear ☐ PSA ☐ Rectal Exam

Other practitioners you see _____

Your local pharmacy: _____

Your mail order pharmacy: _____