



Health History Form

Patient Name: _____ DOB: __/__/__

Age: _____ Today's Date: _____ Preferred Pharmacy: _____

Birth Sex: Male Female

<p>Gender Identity:</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans: Female to Male</p> <p><input type="checkbox"/> Trans: Male to Female</p> <p><input type="checkbox"/> Genderqueer <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Decline to respond</p>	<p>Sexual Orientation:</p> <p><input type="checkbox"/> Straight or heterosexual</p> <p><input type="checkbox"/> Lesbian or gay</p> <p><input type="checkbox"/> Bisexual <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Don't know <input type="checkbox"/> Decline to respond</p>
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Medications (include supplements, inhalers, birth control and over the counter medications):

Name	Strength	How often?

Allergies (especially medications, specify reaction): Latex Allergy? Yes No

Past Surgical History (please include year):

Appendectomy _____, Gall Bladder Removal _____, Tonsillectomy _____,
 Hernia Repair _____, Hysterectomy _____,
 Mastectomy _____, Ovaries _____, Pacemaker _____,
 Heart Stents _____, C-Section _____,
 Tubal Ligation _____, Other: _____

Trauma, Hospitalizations, or Serious Illnesses:

***Have you seen other medical providers for routine or specialty care?** Yes No

1. Provider Name:	Date:	Seen for:
2. Provider Name:	Date:	Seen for:
3. Provider Name:	Date:	Seen for:
4. Provider Name:	Date:	Seen for:

*The care team will ask you to sign a release so we may obtain your records from these providers. Access to these records ensures we can give you the best care possible.



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Health Hazards (quantity, frequency, and duration of use):

Alcohol: Yes No If yes, how often? _____

**Tobacco: Yes No If yes, how often? _____ What substance(s)? _____

**If you do not use tobacco now, have you in the past? Yes No | When did you quit? _____

Marijuana Yes No If yes, how often? _____

Caffeine: Yes No If yes, how often? _____

Drugs: Yes No If yes, how often? _____ What substance(s)? _____

Occupational Concerns (Work Exposure): Your Occupation (Current or former): _____

Job Status: Active Retired

Safety/Preventative: Does the Patient use the following?

Seatbelt: <input type="checkbox"/> Yes <input type="checkbox"/> No	Smoke Alarms: <input type="checkbox"/> Yes <input type="checkbox"/> No
Helmets: <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there guns in home? <input type="checkbox"/> Yes <input type="checkbox"/> No
Carbon Monoxide Detectors: <input type="checkbox"/> Yes <input type="checkbox"/> No	Use of sunscreen <input type="checkbox"/> Yes <input type="checkbox"/> No

For WOMEN ONLY	
Have you had a recent PAP test? <input type="checkbox"/> Yes/Date: ____/____ <input type="checkbox"/> No	Have you had a Mammogram? <input type="checkbox"/> Yes/Date: ____/____ <input type="checkbox"/> No
Age of First Menstrual Period:	Menopause Age:
Last Menstrual Period:	Number of Pregnancies:
Number of Children:	

Miscellaneous Tests: Have you had any of the following?

- Colonoscopy: Yes/Date: ____/____ No
- Dental Exam: Yes/Date: ____/____ No
- Eye Exam: Yes/Date: ____/____ No
- Recent Hospitalization: Yes/Date: ____/____ No
- Recent Labs: Yes/Date: ____/____ No

Patient Name: _____ **DOB:** ___/___/___

Mental Health:

Over the past 2 weeks, have you been bothered by any of the following?

1. Little interest or pleasure in doing things:
 Not at all Several days More than half the days Nearly everyday
2. Feeling down, depressed, or hopeless:
 Not at all Several days More than half the days Nearly everyday

Personal Medical History			Family Medical History		
Yes	No	Medical Problem	Yes	No	Relationship
		Diabetes Mellitus			
		Hypertension (High Blood Pressure)			
		Hyperlipidemia (High Cholesterol)			
		Heart Disease (Angina, Heart Attack)			
		Congestive Heart Failure			
		Asthma			
		Lung Disease (COPD, Emphysema)			
		Stroke or TIA			
		Seizure Disorder			
		Mental Illness (Depression, Anxiety)			
		Abdominal Problems (Peptic Ulcer, Reflux, Colitis, Pancreatitis, Hepatitis)			
		Kidney Stones, Renal Failure			
		Anemia, Sickle Cell, Clotting disorder			
		Arthritis			
		Thyroid disease			
		Eye Disease (Cataracts, Glaucoma)			
		Skin Disorders (Eczema, Psoriasis)			
		Environmental or Food Allergies			
		Cancer or Leukemia Type:			
		Alcoholism			
		Sexually Transmitted Disease, AIDS			
		Physical or Mental Disabilities			