Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. Please take time to complete this questionnaire before your appointment. Thank you!

Main reason for today’s visit: _____________________________________________________________

REVIEW OF ORGAN SYSTEMS: Please check any current and past problems.

___ Abnormal sense of taste or smell 
___ Arthritis 
___ Blood/Bleeding Disorders 
___ Breathing with mouth open at night 
___ Cancer 
___ Cough, Wheeze or Shortness of Breath 
___ Diabetes 
___ Dizziness 
___ Fever 
___ Gastrointestinal Disorder, Heartburn or Indigestion 
___ Headaches 
___ Heart Disease 
___ High Blood Pressure 
___ Immunologic Disease 
___ Infections Disease (HIV/TB) 
___ Insect Allergy 
___ Lung Disease 
___ Neurological Disorder/Seizures 
___ Psychological Disorder/Depression 
___ Skin Disease 
___ Snoring 
___ Thyroid Disorder 
___ Unexplained change in weight

What medications are you taking? (include over-the-counter products, vitamins, birth control, and herbal remedies)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose (e.g., mg/pill)</th>
<th>How many times per day</th>
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Have you been hospitalized? Please list approximate dates and reasons:

________________________________________________________________________________________

________________________________________________________________________________________

Have you had surgery? Please list approximate dates and reasons:

________________________________________________________________________________________

________________________________________________________________________________________

Do you have any medication allergies? Yes ____ No ____
If YES please list: ____________________________________________________________

Do you have any food allergies? Are there any foods you suspect? Yes ____ No ____
If YES please list: ____________________________________________________________
FAMILY HISTORY (Please indicate family members with any of the following conditions):

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<thead>
<tr>
<th></th>
<th>Mother</th>
<th>Father</th>
<th>Sibling</th>
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<tbody>
<tr>
<td>Allergies</td>
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<td>Hay fever</td>
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<td>Chronic stuffy/runny nose</td>
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<td>Sinus problems</td>
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<td>Asthma</td>
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<td>Allergies to food</td>
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<td>Immunologic disorder</td>
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<td>Respiratory diseases</td>
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<td>Skin disorders</td>
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<td>Heart Disease</td>
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<td>Cancer</td>
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<td>Thyroid disease</td>
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<td>Diabetes</td>
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<td>High blood pressure</td>
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<td>Other ____________________________</td>
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</table>

ENVIRONMENT:
Do you have pets at home?   Yes ___   No ___
If YES, please circle:   Cat   Dog   Bird   Other ____________________________
List Breed: _____________________________________________________________________________________________

Do you smoke?   Yes ___   No ___
Have you ever smoked?   Yes ___   No ___
Quit Date: _________

How many packs per day? _________
# of years _________

Are there any smokers living in the home?   Yes ___   No ___

What type of work do you do? ______________________________________________________________________________
Are you exposed to anything at work that you are concerned may affect your health? ______________________________________________________________________________

When was your last chest x-ray? (Please list date and where it was done) ____________________________________________

IMMUNIZATIONS:
Are the patient’s immunizations up to date:   Yes ___   No ___
If NO, please explain: ________________________________________________________________________________

Did you have the influenza vaccine this year?   Yes ___   No ___

Who completed this form? _________________________________________________________________________________
Name ____________________________
Relation ____________________________

In Office Use Only:
Reviewed by: ____________________________