# HEALTH HISTORY

Welcome to our Practice. As a new patient, please fill out the information below to the best of your ability

Date: / /

Patient Name: _____ DOB: _____/_____/_____

**Current Medications**:

| | | |
|---|---|---|
| 1- | 2- | 3- |
| 4- | 5- | 6- |
| 7- | 8- | 9- |

**Allergies**: Medications: _____ Foods: _____

Past Medical History. Have you ever had the following: (Circle "no" or "yes" or leave blank if uncertain)

| | | | |
|---|---|---|---|
| Measles . . . . no yes | Arthritis . . . . no yes | Glaucoma. . . .no yes | Infection Mono . .no yes |
| Mumps . . . . no yes | Veneral Disease . . no yes | Hernia . . . . no yes | Bronchitis . . . no yes |
| Chickenpox. . . no yes | Anemia . . . . no yes | Transfusions . . . no yes | Mitral Valve Prolapse no yes |
| Whooping cough . no yes | Bladder Infections. . no yes | Back pain . . . .no yes | Stroke . . . . no yes |
| Scarlet Fever. . . no yes | Epilepsy. . . . no yes | High blood pressure. no yes | Hepatitis . . . no yes |
| Diphtheria. . . no yes | Migraine Headache. no yes | Low Blood pressure. no yes | Gastritis . . . no yes |
| Smallpox. . . . no yes | Tuberculosis . . . no yes | Hemorrhoids. . . no yes | Kidney Disease . . no yes |
| Pneumonia. . . no yes | Diabetes . . . . no yes | Asthma . . . no yes | Thyroid disease . .no yes |
| Rheumatic Fever. . no yes | Cancer . . . . no yes | Hive or Eczema . .no yes | |
| Heart Disease. . no yes | Polio . . . . . no yes | HIV+ or AIDS . . no yes | |

**Previous Surgery**/Serious Illness When? Hospital, City, State

_____ _____ _____

_____ _____ _____

**Social History**

Use of Alcohol Never ___ Rarely ___ Moderate___ Daily ___

Use of Tobaco Never ___ Quit ___ Current Pack/day_____

Use of Drugs Never ___ Type of Drug _____ Frequency _____

**Family Medical History**

| | Age | Disease | if Disease Cause of Death |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |

To the best of my knowledge, the question on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date