

# HEALTH HISTORY FORM

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

**PHARMACY PREFERENCE**

Local Pharmacy Name \_\_\_\_\_ Town \_\_\_\_\_ Street \_\_\_\_\_

**PATIENT'S MEDICAL HISTORY (circle yes or no)**

Alcohol/Drug Abuse	Yes	No	Cataract	Yes	No	Heart Attack	Yes	No	Nerve/Muscle Disease	Yes	No
Allergies (other than meds)	Yes	No	Circulation Problems	Yes	No	Heartburn/GERD /Ulcers	Yes	No	Osteoporosis	Yes	No
Anemia	Yes	No	Colitis/Bowel Disease	Yes	No	High Blood Pressure	Yes	No	Pneumonia	Yes	No
Anxiety	Yes	No	Congeslive Heart Failure	Yes	No	HIV/AIDS	Yes	No	Seizures	Yes	No
Arthritis	Yes	No	Chronic Obstructive Pulmonary Disease	Yes	No	Jaundice	Yes	No	Sickle Cell	Yes	No
Asthma	Yes	No	Depression	Yes	No	Kidney Disease	Yes	No	Stroke	Yes	No
Birth Defect/ Genetic Problem	Yes	No	Diabetes	Yes	No	Meningitis	Yes	No	Thyroid Disease	Yes	No
Blood Clots	Yes	No	Emphysema	Yes	No	Mental Health Problems	Yes	No	Tuberculosis	Yes	No
Blood Transfusion	Yes	No	Glaucoma	Yes	No	Murmur	Yes	No	Viral Hepatitis	Yes	No
Cancer	Yes	No	High Cholesterol	Yes	No	ADD/ADHD	Yes	No	Foot Problems?	Yes	No

Other Medical History: \_\_\_\_\_

**PATIENT'S SURGICAL HISTORY (circle yes or no)**

Abdomen Surgery	Yes	No	Brain Surgery	Yes	No	C-Section	Yes	No	Hernia Repair	Yes	No
Appendectomy	Yes	No	Breast Surgery	Yes	No	Cholecystectomy (Gallbladder)	Yes	No	Hysterectomy	Yes	No
Surgical Repair: Broken Bones/Fractures	Yes	No	Colon Surgery	Yes	No	Adnoid/ Tonsillectomy	Yes	No	Joint Replacement	Yes	No
Coronary Artery Bypass Graft	Yes	No	Cosmetic Surgery	Yes	No	Sterilization	Yes	No	Ear Tubes	Yes	No

Other Surgical History: \_\_\_\_\_

**PATIENT'S SOCIAL HISTORY for 10 YRS OLD and UP**

<b>Tobacco Use</b>	Yes NEVER Quit Passive					Comment _____ Years of Smoking .5 1 2 3 4 5 10 other _____		
	Packs/Day	.25	.5	1	1.5		2	3
	Quit Date							
<b>Alcohol Use</b>	Yes	No					Comment _____	
	Drinks/Week	Glass(es) of Wine						
		Can(s) of Beer						
		Shot(s) of Liquor						
	Drinks containing 0.5 oz of alcohol							
<b>Illegal Drug Use</b>	Yes	No					Comment _____	
	Per Week					Types		Marijuana Cocaine
<b>Sexually Active</b>	Yes	No	Not Currently				Comment _____	
	Gender of Partners	Female	Male					

Birth Control/Protection : \_\_\_\_\_ Condom Pill IUD Surgical Spermicide Rhythm Injection Abstinence

**OVER----->**

Please complete the information below relating to your family's medical history

Place an "X" in the appropriate box below (see example)

**PATIENT'S FAMILY HISTORY**

Relationship	Name	Status	Cancer: Type and age of death (if app)	Diabetes- Type	Heart Failure	Hypertension (High Blood Pressure)	Asthma	High Cholesterol	Arthritis - Rheumatoid	Arthritis - Osteo	Stroke	Thyroid Disease	Seizures	Migraines	Rashes / Skin Problems	Other
Example	Sister	Sally	Alive/Deceased	X			X				X					
Parents	Mother		Alive/Deceased													
Parents	Father		Alive/Deceased													
Siblings			Alive/Deceased													
Siblings			Alive/Deceased													
Siblings			Alive/Deceased													
Siblings			Alive/Deceased													
Siblings			Alive/Deceased													
Patient's Children			Alive/Deceased													
Patient's Children			Alive/Deceased													
Patient's Children			Alive/Deceased													
Patient's Children			Alive/Deceased													
Grandparents	<sup>1</sup> MGM		Alive/Deceased													
Grandparents	<sup>1</sup> MGF		Alive/Deceased													
Grandparents	<sup>2</sup> PGM		Alive/Deceased													
Grandparents	<sup>2</sup> PGF		Alive/Deceased													

1: Maternal  
2: Paternal

**FEMALE**

HEALTH MAINTENANCE	DATE
Last Pap Smear/Gyne Exam	
Last Mammogram	
Last Dexa Scan	
Last Colonoscopy	
Last Tdap/tetnus	
Last Pneumovax	
Last Flu Shot	
Zostavax	

**MALE**

HEALTH MAINTENANCE	DATE
Last PSA	
Last Colonoscopy	
Last Tdap/ Tetnus	
Last Pneumovax	
Last Flu Shot	
Zostavax	

Do you see other physicians? Yes No

Name \_\_\_\_\_

For what? \_\_\_\_\_

Name \_\_\_\_\_

For what? \_\_\_\_\_

Name \_\_\_\_\_

For what? \_\_\_\_\_

Name \_\_\_\_\_

For what? \_\_\_\_\_