HEALTH HISTORY

Patient Name: _____ **D.O.B.** _____

Date	**Medical History** (illness / hospitalizations)	Date	**Surgeries / Injuries** (eg: broken bones, etc.)

Allergies: _____

FAMILY HISTORY: (If deceased, indicate age.)

Illness	Relative (eg. Parents, grandparents, siblings, etc.)
High Blood Pressure	
Heart Disease	
Stroke	
High Cholesterol	
Asthma	
Cancer: Breast:	
Colon:	
Prostate:	
Other:	
Alcoholism	
Psychiatric Illness	
Diabetes	
Thyroid Disease	
Osteoporosis	
Blood Clots	
Other	

SOCIAL HISTORY:

Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widowed **Significant Other's Name:** _____

Children's Names & year born: _____

Occupation: _____ **Religious Preference:** _____

Habits: Tobacco: ❑ Current Year quit _____ Alcohol: ❑ Current Year quit _____ Recreational Drug use: ❑ Current Year quit _____

Living Will ? ❑ Yes ❑ No Power of Attorney ? ❑ Yes ❑ No Name: _____ Relationship: _____