

NAME:

Today's Date:

Previous or referring doctor:

Date of last physical exam:

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

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Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

List your prescribed drugs and over-the-counter drugs, such as vitamins, supplements, birth control, and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

Are you allergic to latex, acrylic, or tape?

Exercise	<input type="checkbox"/> Sedentary (No exercise)
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Amount of weight lost/gained in the last 6 months		
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How often and what type do you consume in a given week?		
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever tested positive for HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
FAMILY HISTORY			
Has any blood relative had abnormal bleeding?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has any blood relative had abnormal clotting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has any blood relative had anesthetic complications/problems?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has any blood relative had breast or ovarian cancer?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has any blood relative had skin cancer or melanoma?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has any blood relative had resistant staph infections or MRSA?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
PERSONAL HISTORY			
Do you wear contact lenses or corrective glasses?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear dentures?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have problems with anesthesia?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have fainting spells		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have chest pain or angina?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have anemia?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have abnormal bleeding?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have abnormal blood clotting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have asthma?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have diabetes?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a heart attack?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have hepatitis?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have resistant staph infections or MRSA?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have sleep apnea?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have high blood pressure?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had or do you now have any serious illness?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(WOMEN ONLY) Are you pregnant or breastfeeding?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(WOMEN ONLY) Have you been pregnant? If so, list ages of children:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(WOMEN ONLY) Did you breast feed any of your children? If so, for how long?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(WOMEN ONLY) Have you ever had a mammogram? If so, when?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(WOMEN ONLY) Have you ever had any problems with your breasts?		<input type="checkbox"/> Yes	<input type="checkbox"/> No