Patient Health History

Name _____ Date _____ Age _____

Please fill out the information below to provide us with background on your personal health history. This information will remain confidential, and will be part of your patient record.

Thank you.

Allergies

Please list allergies: _____

_____

Family History

Which of the following illnesses have you, or any of your blood relatives had? *(Please check all that apply.)*

	I have had:	My blood relatives have had:
Chicken Pox	❑	❑
Measles	❑	❑
Mumps	❑	❑
Rubella (German Measles)	❑	❑
Rheumatic Fever	❑	❑
Tuberculosis	❑	❑
Thyroid Disease	❑	❑
Asthma	❑	❑
Diabetes	❑	❑
Epilepsy or Convulsions	❑	❑
Rheumatism or Arthritis	❑	❑
Heart Disease	❑	❑
Lung Disease	❑	❑
Hepatitis or Jaundice	❑	❑
Kidney or Bladder Infection or Stone	❑	❑
Mental or Nervous Breakdown	❑	❑
Sexually Transmitted Disease	❑	❑
Tumor or Cancer	❑	❑
Peptic Ulcer Disease	❑	❑
Anemia	❑	❑
Glaucoma or Cataracts	❑	❑
Alcoholism	❑	❑
Stroke	❑	❑
Pneumonia	❑	❑
Gall Bladder Disease	❑	❑
Depression	❑	❑
Hypertension/High Blood Pressure	❑	❑
HIV Virus/AIDS	❑	❑
Skin Disease	❑	❑
Sickle Cell Anemia	❑	❑
Bronchitis	❑	❑
Allergies, Hayfever, Eczema	❑	❑

Which of these symptoms do you experience on a regular basis? *(Please check all that apply.)*

- Heartburn ❑
- Breathing and swallowing problems ❑
- "Back-wash" of stomach contents into the mouth at night ❑
- Morning hoarseness ❑
- Upset stomach ❑
- Abdominal pain ❑
- Nausea or vomiting ❑
- Gas, bloating or belching ❑

Hospitalization

Please indicate your most recent hospitalization.

Year	Operation/Illness	Hospital/Location

Medications

Are you currently taking prescription medication? ❑ YES ❑ NO

If yes, which medication(s)? _____

_____

_____

Are you currently taking any over-the-counter medication? ❑ YES ❑ NO

If yes, which medication(s)? _____

_____

Medications

Are you currently taking prescription medication? ❑ YES ❑ NO

If yes, which medication(s)? _____

_____

_____

Pregnancies

Are you pregnant now? ❑ YES ❑ NO ❑ NA

Have you been pregnant? ❑ YES ❑ NO ❑ NA

# of pregnancies _____ # of abortions _____ # of miscarriages _____ Contraceptive method _____

Social Health History

Do you take antacids more than three times a week? ❑ YES ❑ NO

Do you have a regular exercise program? ❑ YES ❑ NO

Do you smoke? ❑ YES ❑ NO

If yes, please list number of packs per day: _____

Do you drink alcoholic beverages? ❑ YES ❑ NO

If yes, please list amount/frequency: _____

Have you been outside of the U.S. within the last 12 months? ❑ YES ❑ NO