

PATIENT HEALTH HISTORY

Patient Information					
NAME:		SSN:		DATE:	
Chief Complaint:					
Drug Allergies		Current Medications		Family History	
_____		_____			Father
_____		_____			Mother
_____		_____			Grand Parents
_____		_____			Siblings
_____		_____			Children
_____		_____		Heart Disease	
_____		_____		High Blood Pressure	
_____		_____		Diabetes	
_____		_____		Stroke	
_____		_____		Cancer	
Hospitalizations or Surgeries					
Reason		Date		Reason	
Women Only: Any Chance You Could Be Pregnant Y N LMP _____					
Medical History					
Hypertension		Gall Bladder Disease		Stroke	
Heart Disease		Urinary Incontinence		Cancer	
Angina		Bowel Incontinence		Epilepsy / Seizures	
Diabetes		Enlarged Prostate		Kidney Disease	
Asthma		Hepatitis		Thyroid Disease	
Bronchitis		Anemia		Sexual Dysfunction	
COPD / Emphysema		Arthritis		Menstrual Irregularities	
Acid Reflux		Osteoporosis		Bleeding Disorder	
Constipation		Depression		Mental Illness	
Irritable Bowel		Migraine Headaches		Other:	
Habits					
Smoke: Y N		Pack/Day:		Alcohol: Never Social Daily	