

## Health History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Please mark any conditions that you or your blood relatives have. (Blood relatives may be defined as parents; brothers and sisters; and grandparents, if relevant.)

<u>You</u>	<u>Your blood relatives</u>	
-	-	Heart disease
-	-	High blood pressure
-	-	High cholesterol
-	-	Stroke
-	-	Asthma, Emphysema
-	-	Cancer (type: _____)
-	-	Thyroid disease
-	-	Diabetes
-	-	Eye diseases, glaucoma, blindness
-	-	Arthritis, osteoporosis
-	-	Blood disorders (anemia, leukemia)
-	-	Auto-immune diseases (lupus, rheumatoid arthritis)
-	-	Depression
-	-	Other psychiatric disease
-	-	Ulcers or intestinal disease
-	-	Gall bladder or liver disease
-	-	Alcoholism/substance abuse
-	-	Obesity
-	-	Other important disease: _____

Please list all medicines, herbs, and vitamins that you take regularly. Give doses if you know them:


Are you allergic to any medication or to latex?

\_\_\_\_\_

\_\_\_\_\_

(Please complete both sides.)

Have you ever been treated for psychiatric illness? Please list:

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Have you ever been hospitalized or had surgery? Please list each occasion with the approximate year:

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	<u>Never</u>	<u>Used to, but quit</u>	<u>Yes</u>
Do you drink alcohol?	-	-	-
Smoke cigarettes?	-	-	-
Use recreational or street drugs?	-	-	-

	<u>Never</u>	<u>Sometimes</u>	<u>Often</u>
Exercise regularly?	-	-	-
Eat a healthy, varied diet?	-	-	-

What is your occupation?

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Have you had more than one sex partner in the past year?  Yes  No

Have you been at risk for HIV, hepatitis, or other sexually transmitted diseases?  Yes  No

<b>Women only:</b>	<u>Yes</u>	<u>No</u>
Do you check your breasts for cancer?	-	-
Do you have periods?	-	-
Have you ever had an abnormal Pap Smear?	-	-
How many times have you been pregnant? _____		
births _____ miscarriages/abortions _____ living children _____		

<b>Men only:</b>	<u>Yes</u>	<u>No</u>
Do you check your testicles for cancer?	-	-
Have you ever had a high PSA (blood test)?	-	-
Difficulty urinating?	-	-
Get up to urinate more than 3 times a night?	-	-

Is there anything else you think your doctor should know?

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(Please complete both sides.)