

PATIENT HEALTH HISTORY

PATIENT NAME: _____ AGE: _____

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Primary Care Doctor: _____

Smoking (type & amount per day) _____ Alcohol (type & amount per week) _____
If former smoker, date quit: _____ Weight _____ Height _____

Drug allergies and reactions: _____

List previous surgeries or major illnesses and dates: _____

List any medications you are taking, including non-prescription, vitamins and herbals: _____

Family History:

Has any blood relative ever had the following? (check all that apply):

Breast Cancer		High Blood Pressure		Kidney Disease	
Melanoma		Heart Disease		Depression	
Stroke		Diabetes			

Past Medical History:

Have you ever had the following?: (check all that apply)

Heart Disease		Cancer		Stomach Ulcer	
Arthritis		Glaucoma		Kidney Disease	
Rheumatic Fever		Asthma		Thyroid Disease	
Anemia		AIDS or HIV+		Bleeding Tendency	
Tuberculosis		Stroke		Mitral Valve Prolapse	
Diabetes		Hepatitis		High Blood Pressure	

Review of Symptoms:

Do you have or have you had within the past year: (check all that apply)

Weight Changes		Swollen feet/ankles		Seizures	
Dry Eyes		Skin Rash		Joint/Muscle Pain	
Chronic Cough		Chronic Diarrhea		Swollen Lymph Nodes	
Chest Pain		Jaundice		Easy Bleeding	
Rapid Heart Beat		Depression		Easy Bruising	

Women Only:

Date of last mammogram _____ Have you had/or plan to have any:
Do you do regular breast self-exams? ___Yes___No Chemotherapy ___Yes___No
Have you had a breast lump or discharge? ___Yes___No Radiation ___Yes___No
Did you breast feed? ___Yes___No Date of last Treatment _____
Bra size _____

I verify that the above information is true and accurate to the best of my knowledge.

X _____
Signature of Patient or Parent if Minor

Date