Patient Health History Information

Dictated:____

Name: _____ Sex: _____ Today's Date: _____

Age: _____Birth Date: _____ Height: _____ Weight: _____ Date of Last Physical Exam:_____

***PLEASE indicate the PRIMARY reason for consultation with the Doctor:_____

PAST MEDICAL HISTORY: Have you ever had any of the following problems? If yes, please explain.

EYE, EAR, NOSE OR THROAT? ☐ NO ☐ YES If yes (other than cold/flu symptoms), explain: _____
SKIN, MUSCLES, JOINTS, BONES? ☐ NO ☐ YES If yes, explain: _____
GENITO-URINARY? ☐ NO ☐ YES If yes, explain: _____
GASTROINTESTINAL (ABDOMINAL AREA)? ☐ NO ☐ YES If yes, explain: _____
CARDIOVASCULAR? ☐NO ☐ YES If yes, explain: _____
BLOOD OR LYMPHATIC? ☐ NO ☐ YES If yes, explain: _____
ARE YOU TAKING ASPIRIN OR ASPIRIN PRODUCTS? ☐ NO ☐ YES If yes, how often: _____
HAVE YOU EVER REFUSED A RECOMENDED SURGERY? ☐ NO ☐ YES If yes, explain:_____
HAVE YOU EVER HAD BLOOD TRANSFUSION? ☐ NO ☐ YES If yes, explain:_____

PAST MEDICAL CONDITIONS: Check (√) conditions you currently have or have had in the past.

☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Bone/Joint Disease
☐ Breast Lump
☐ Bursitis
☐ Cancer
☐ Colitis
☐ Diabetes
☐ Epilepsy
☐ Hemorrhoids
☐ Gall Bladder Disease
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herpes
☐ High Cholesterol
☐ HIV Positive
☐ Hypertension
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Liver Disease
☐ Multiple Sclerosis
☐ Nervous Breakdown
☐ Pacemaker
☐ Pneumonia
☐ Prostate Problem
☐ Psychiatric Care
☐ Rheumatic Fever
☐ Scarlet Fever
☐ STD- Sexual Diseases
☐ Stroke
☐ Thyroid Problem
☐ Tuberculosis
☐ Ulcers

FEMALES:
Last Menstrual Period _____
Last Pap Smear_____
Last Mammogram _____

PREGNANCIES:
Number of Pregnancies _____
Number of Live Births_____
Number of Miscarriages_____
Number of Abortions _____
Are you pregnant _____

	FAMILY HISTORY	
√	**Check if any blood relative has ever had:**	**Relationship**
	Arthritis	
	Asthma, Hay Fever	
	Cancer	
	Diabetes	
	Epilepsy	
	Heart Disease, Stroke	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	
	Other	

MEDICATIONS
List medications you are presently taking:
☐ None / Not Applicable
ALLERGIES/REACTIONS: Medications/Substances
☐ None / Not Applicable

SURGERIES	
Surgeries / Hospitalizations	
Year	**Description**
ALLERGIES/REACTIONS: Food (Soy, Nuts, Gluten)	
☐ None / Not Applicable	
Do you carry an EPI-PEN? ☐ NO ☐ YES	

SOCIAL HISTORY

Smoke? ☐ NO ☐ YES
_____ # of packs per day

Alcohol? ☐ NO ☐ YES
_____ # of drinks per week

Caffeine? ☐ NO ☐ YES
Drug Abuse? ☐ NO ☐ YES

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Schenden/Harake/Kroese responsible for any omissions/errors I have made in completing this form. This information is confidential and will not be released without consent.

Signature: _____ Date: _____ Reviewed By:_____ Date: _____