HEALTH SUMMARY

Patient name (please PRINT): _____ DOB: _____

Weight:_____ Height:_____

ALLERGIES **NONE: _____**

MEDICATIONS **NONE: _____**

What medications are you taking (including birth control pills, herbals, vitamins, dietary supplements, and over-the counter)?

PRESENT HEALTH CONDITIONS

YES	NO	DISEASE		YES	NO	DISEASE
		Irregular Heart Beat				Prostate Problems
		Congestive Heart Failure				Gout
		Heart Attack				Arthritis
		Heart Murmur				Skin Disease, Type:
		Rheumatic Fever				Stroke
		High Cholesterol				Epilepsy/Seizures
		High Blood Pressure				Diabetes/High Blood Sugar
		Asthma				Thyroid Problems – too high or too low
		Emphysema/Chronic Bronchitis				Anemia/Low Blood
		Blood Clot in Lung				Bleeding Problems, Type:
		Blood Clot in Leg				Blood Transfusion
		Tuberculosis				Cancer, Type:
		Gallstones				Anxiety
		Liver Disease, Type:				Depression
		Ulcers in Bowel/Stomach				Glaucoma
		Bleeding from Bowels				Other:
		Kidney Disease, Type:				
		Kidney Stones				

SURGERIES

YES	NO	DISEASE		YES	NO	DISEASE
		Cataract Surgery, Left Right				Joint Replacement of Knee / Hip
		Tonsils Removed				Back Disc Surgery
		Neck Artery Surgery				Prostate Surgery
		Open Heart Surgery/Catheterization				Hernia Surgery
		Appendectomy				Vasectomy
		Gallbladder Removal				Hysterectomy
		Abdominal Surgery				Other:
		Broken Bone Repair				
		Joint Scope Surgery				

(OVER)

FAMILY HISTORY

YES	NO	DISEASE	RELATION TO YOU	YES	NO	DISEASE	RELATION TO YOU
		Heart Attack				Bleeding Problems	
		High Blood Pressure				Sickle Cell Anemia	
		High Cholesterol				Diabetes/High Blood Sugar	
		Asthma				Thyroid Problems	
		Tuberculosis				Cancer, Type:	
		Liver Disease				Cancer, Type:	
		Kidney Disease				Alcohol Abuse	
		Gout / Arthritis				Anxiety or Depression	
		Osteoporosis				Glaucoma	
		Stroke				Other:	
		Epilepsy / Seizures					

OTHER HISTORY

Exercise: ❑ Never ❑ Rarely ❑ Other: _____

When was your last: Tetanus _____, (Never) ___ / Hepatitis B _____, (Never) ___ / Pneumovax _____, (Never) ___
Flu shot _____, (Never) ___

Smoking:
Have you ever smoked: ❑ Yes ❑ No How many years did you smoke? _____ When did you quit? _____
How many packs per day do you smoke now? _____ Do you use smokeless tobacco: ❑ Yes ❑ No

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol/Drugs:

❑ Yes ❑ No Do you drink? How much? _____ How often? _____

❑ Yes ❑ No Do you use drugs? How much? _____ How often? _____ What kind? _____

What drugs have you used in the past? _____

FEMALE PATIENTS ONLY

of Pregnancies: _____ # of Deliveries: _____ # of Elective Abortions: _____ # of Miscarriages: _____

When was your last menstruation? _____ How old were you when you went through Menopause? _____

When was your last Pap smear? _____ Have you ever had an abnormal Pap smear? ❑ Yes ❑ No

If "Yes," when was the abnormal Pap smear? _____

What was the abnormality? _____

What kind of treatment did you have? _____

When was your last Mammogram? _____ Have you ever had an abnormal Mammogram? ❑ Yes ❑ No

If "Yes," when was the Mammogram? _____

The above information is current and correct to the best of my knowledge. **I have reviewed the above history.**

_____ _____ _____ _____

Patient/Guardian Signature **Date** **Physician's Initial** **Date**