

WESTCHASE HEALTH CLINIC

HEALTH HISTORY

Name: _____
Last First Middle Initial
SSN: _____ - _____ - _____ Home phone :(_____) _____

MR#: _____
Date of birth: _____
Age: _____
Gender: M _____ F _____

What is the reason for your office visit today? _____

PAST MEDICAL HISTORY (List all diseases, conditions with year of onset)

PASTSURGICALHISTORY(with year of surgery and dates of hospitalizations)

MEDICATIONS (List all meds, strength & frequency, include non-prescriptions & herbs/supplements as well)

ALLERGIES (List all medications, foods or agents & the reaction)

No Allergies: _____

SOCIAL HISTORY:

Tobacco: Current use: _____ How much? _____ pack/day Duration: _____ mth /years
Past use: _____ How much? _____ pack/day Duration: _____ mth /years
Quit Date: _____

Alcohol: Current use: _____ How much? _____ day/wk Duration: _____
Past use: _____ How much? _____ day/wk Duration: _____
Quit Date: _____

Exercise: Yes _____ No _____ Type: _____ How long? _____ Frequency _____

Diet: _____ Occupation: _____

Sexual activity: Yes _____ No _____ Any history of sexually transmitted disease? _____
When? _____ Was it treated? _____

FAMILY HISTORY:

Indicate if any immediate family members have the following conditions or diseases:

____ Alzheimer's disease _____ Diabetes _____ Osteoporosis _____ Breast or Ovary cancer
____ Anemia _____ Hypertension _____ Prostate Cancer _____ Prostrate Cancer
____ Bleeding Disorder _____ Thyroid Disease _____ Stomach or Colon Cancer
____ Breast Cancer _____ Melanoma _____ Early Heart attack / coronary artery disease

IMMUNIZATION HISTORY:

When was your most recent?

Tetanus Shot (Td) / DTap: _____ Hepatitis B: _____ Pneumococcal Vaccine: _____ Flu: _____

PAST PREVENTIVE CARE:

When was your most recent?

Annual Physical Exam: _____ Well Woman Exam: _____ Eye Exam: _____
Mammogram: _____ Bone Density Test: _____ PSA/Prostate Screen: _____
Colonoscopy / Sigmoidoscopy: _____ EKG: _____

Do you have a Living Will or Durable Power of Attorney for healthcare? _____ Yes _____ No

Patient Signature: _____ Date: _____

Physician Comments: