Heart and Family Health Institute - Health History

Name: _____ Date of birth: _____ Height: _____ Weight: _____

Reason for visit today: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

Have you ever smoked? ☐ Yes ☐ No If yes, when did you quit? _____

Do you use alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you or have you used the following in the last three months? ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Crack ☐ Methamphetamine

Are you allergic to any medications? Yes or No (If yes, please list.)

Current Medications	Dosage

Previous Surgery	Date

Have <u>you</u> ever had any of the following? <u>Check all that apply</u>:

__ Alcoholism __ Epilepsy-Seizures __ Kidney Disease __ Stroke
__ Asthma __ Gout __ Lung Disease __ Thyroid Blood Clot
__ Bladder problems __ Heart Disease __ Prostate __ Tuberculosis
__ Cancer __ High Blood Pressure __ Psychiatric Disorder __ Other _____
__ Depression-Anxiety __ Jaundice-Liver __ Skin Disease __ Other _____
__ Diabetes __ Joint Disease __ Stomach Problems __ Other _____

Do any of these conditions <u>run in your family</u>? <u>Check all that apply</u>:

__ Alcoholism Addiction __ Diabetes __ Joint Disease __ Stroke
__ Blood Clots __ Heart Disease __ Psychiatric Disorder

Preventative Care Information:

When was your last mammogram? _____ Location: _____ ☐ N/A

When was your last colonoscopy? _____ Location: _____ ☐ N/A

If Diabetic, have you had an eye exam? __Yes __ No If Yes, Where? _____ ☐ N/A

Primary care physician information:

Name: _____ Phone number:_____

Address: _____

Pharmacy information:

Name: _____ Phone number: _____

Address: _____

Last Updated: July 2017