# Health History Form

**Patient Name:** ______________________________ **Date of Birth:** ____________
**Primary Care doctor:** ________________ **Referring physician:** ______________
**Preferred pharmacy:** ________________ **Pharmacy city:** ________________

**Medications** (Please list or provide the clinical staff a copy of prescriptions at appointment)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Medication Allergies:**

______________________________________________________________________
______________________________________________________________________

**Allergies to Latex? Yes / No** **Allergies to Adhesives? Yes / No**

**Medical History (Please circle all that apply):**

**Cancer: Y/N**

**If yes to above, please specify:**______________________________________________

Headache/Migraine: Y/N
Ear infections: Y/N
Allergies: Y/N
Nosebleeds: Y/N
Sleep Apnea: Y/N
Heart Attack: Y/N; if so, when: __/__
Irregular heart beat: Y/N
High blood pressure: Y/N
Heart Disease: Y/N
Elevated Cholesterol: Y/N

Emphysema/COPD: Y/N
Asthma: Y/N
GERD: Y/N
Intestinal disorder: Y/N
Kidney disease: Y/N
Liver disease/disorder: Y/N
Arthritis (osteo/rheum) Y/N
Seizures: Y/N
Anxiety/Depression: Y/N
Thyroid Nodules: Y/N

Thyroid Hypo/Hyper: Y/N
Diabetes I/II: Y/N
Anemia: Y/N
Bleeding disorders: Y/N
MRSA/STAPH: Y/N
AIDS/HIV: Y/N
Auto-immune disorders: Y/N

**Are there any other disorders not listed above that you've been diagnosed with?:**

______________________________________________________________________

**Surgeries:**

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Flu Shot**: Yes/No: If yes, when? _______ **Pneumonia shot:** Yes/No: If yes, when? _________

**Any immediate family members with the below? (Please circle all that apply):**

**Cancer: Y/N** **Bleeding disorders: Y/N** **Hearing loss: Y/N**

**Social History (Please circle all that apply):**

**Smoking: Y/N** **Smokeless tobacco: Y/N** **Cigars: Y/N** **Vaping: Y/N** **Active: Y/N**

**Alcohol use: None/Rarely/Socially/Daily** **Type: Beer/Wine/Liquor**

**Please briefly describe your current symptoms and your current concerns:**

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________