

Name \_\_\_\_\_

## Health History Form

Have you or an immediate family member (mother, father, sister, brother, or grandparent) ever had any of the following conditions?

	Patient	Family	Check and detail positive findings including date and place of treatment. Precede findings by reference number.
1. Congenital anomalies . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
2. Genetic diseases . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
3. Multiple births . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
4. Diabetes mellitus . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
5. Malignancies . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
6. Ovarian cancer . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
7. Breast cancer . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
8. Hypertension . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
9. Heart attack . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
10. Stroke . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
11. Rheumatic fever . . . . .	<input type="checkbox"/>		
12. Pulmonary disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
13. GI problems . . . . .	<input type="checkbox"/>		
14. Renal disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
15. Genitourinary tract problems . . . . .	<input type="checkbox"/>		
16. Abnormal uterine bleeding . . . . .	<input type="checkbox"/>		
17. Infertility . . . . .	<input type="checkbox"/>		
18. Venereal disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
19. Blood clots - leg or lung . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
20. Phlebitis, varicosities . . . . .	<input type="checkbox"/>		
21. Emotional/psychological disorders . . . . .	<input type="checkbox"/>		
22. Neurologic disorders . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
23. Headaches/migraines . . . . .	<input type="checkbox"/>		
24. Metabol./endocrine disorders . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
25. Anemia/hemoglobinopathy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
26. Blood disorders . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
27. Infectious diseases . . . . .	<input type="checkbox"/>		
28. Skin problems . . . . .	<input type="checkbox"/>		
29. Operations/accidents . . . . .	<input type="checkbox"/>		
30. Allergies/meds sensitivity . . . . .	<input type="checkbox"/>		
31. Blood transfusions . . . . .	<input type="checkbox"/>		
32. Other hospitalizations . . . . .	<input type="checkbox"/>		
33. Thyroid disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
34. Arthritis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
35. _____	<input type="checkbox"/>	<input type="checkbox"/>	
36. _____	<input type="checkbox"/>	<input type="checkbox"/>	
37. <b>No known disease/problems</b>	<input type="checkbox"/>	<input type="checkbox"/>	

Do you drink alcohol? \_\_\_\_\_ If so, how many drinks per week? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ If so, what do you use? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_

Would you like to quit? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many per day? \_\_\_\_\_ Would you like to quit? \_\_\_\_\_