



HEALTH HISTORY

Date: _____ Date of Birth: _____ Name: _____

Circle medical problems that apply:

- Anxiety Asthma Cancer COPD Depression Diabetes
 Headaches Heart Problems High Blood Pressure High Cholesterol Stroke

Other (Please list) _____

Past Surgeries/Hospitalizations (Include year):

1. _____ 2. _____
 3. _____ 4. _____
 5. _____ 6. _____

Social History

Do you feel safe at home? Yes ___ No ___
 Have you ever been emotionally or physically abused? Yes ___ No ___

Women Only

Date of last menstrual period _____
 Are your periods normal? Yes No
 Have you ever had an abnormal PAP? Yes No
 How many times have you been pregnant? _____
 How many times have you had a miscarriage? _____
 How many times have you had an abortion? _____

(Men & Women Please)

Family History Circle all that apply

- | | | | | |
|---------------------|--------|--------|---------|--------|
| Diabetes | Mother | Father | Brother | Sister |
| Cancer | Mother | Father | Brother | Sister |
| Heart Problems | Mother | Father | Brother | Sister |
| High Blood Pressure | Mother | Father | Brother | Sister |
| High Cholesterol | Mother | Father | Brother | Sister |
| Other _____ | Mother | Father | Brother | Sister |