HEALTHFIRST

Revised 10/2020

Health History

Patient Name:_____ Birth Date:_____

☐ Heart Disease
☐ Congestive Heart Failure
☐ High Blood Pressure
☐ Stroke
☐ Pacemaker
☐ Rheumatic/Scarlet Fever
☐ High Cholesterol
☐ Bleeding Disorders
☐ Edema

☐ Lung Disease
☐ COPD/Emphysema
☐ Asthma
☐ Pneumonia
☐ TB
☐ Allergies

☐ Endocrine Disease
☐ Thyroid Issues
☐ Diabetes
☐ Hypoglycemia

☐ Gastrointestinal Disease
☐ Colon Screening Date_____
☐ Diverticulosis
☐ Irritable Bowel Syndrome
☐ Crohn's Disease
☐ GERD

☐ Neurological Disease
☐ Seizures
☐ Epilepsy
☐ Lyme Disease
☐ Parkinson's Disease
☐ Huntington's Disease

☐ Childhood Diseases
☐ Measles
☐ Mumps
☐ Chicken Pox
☐ Frequent Ear Infections

☐ Rubella
☐ Rashes
☐ Mononucleosis

☐ Muscular/Skeletal Disease
☐ Rheumatoid Arthritis
☐ Arthritis
☐ Fibromyalgia
☐ Osteoporosis
☐ Multiple Sclerosis
☐ Back Pain
☐ Joint Replacement (_____)

☐ Liver/Kidney Disease
☐ Hepatitis
☐ Dialysis
☐ Urinary Tract Infections
☐ Bladder Control

☐ Skin Disease
☐ Eczema
☐ Psoriasis

☐ Cancer
Type: _____

☐ Vision
☐ Cataracts
☐ Glaucoma

☐ Other
☐ Prostrate Problems
☐ Migraine Headaches
☐ Sexually Transmitted Diseases
☐ HIV
☐ Weight Loss
☐ Weight Gain
☐ Eating Disorders
☐ Alcohol Intake _____

☐ Do you Exercise? ☐Yes ☐
How Often? _____

☐ Have you ever had a blood Transfusion?

☐ Psychological Illness

Are you employed? ☐Yes ☐No

Are you exposed to hazardous substances? ☐Yes ☐No

Do you smoke? ☐Yes ☐No If yes, how much? _____

Do you use illegal drugs including marijuana? ☐Yes ☐No If Yes, what_____

Family History

Do you have parents, aunts, uncles, brothers or sisters with:

Heart Disease: ☐Yes ☐No If yes, who_____

Lung Disease: ☐Yes ☐No If yes, who_____

Cancer: ☐Yes ☐No If yes, who_____

Diabetes: ☐Yes ☐No If yes, who_____

Other: What_____ Who_____

Other: What _____ Who_____

Other: What _____ Who_____

Medications and/or Supplements Currently Taking_____

_____

_____

ALLERGIES (Please List)

_____

_____

_____

Surgical History/Hospitalization or Inpatient Treatments with Date and Physician Name

_____

_____

_____

_____

Women Only:

Age Period Started_____

Last Period: _____

Last Pap Smear: _____

Any Abnormal Pap Smears (yes/No) _____

Date of Abnormal Pap Smear_____

Are You Pregnant? ☐Yes ☐No

Number of Pregnancies_____

Number of Live Births_____

Birth Control Method Used: _____

History of: (check all that Apply) ☐Colposcopy ☐ Leep ☐Hysterectomy

Dates: _____ _____ _____

Self Breast Exam ☐Yes ☐No

Last Mammogram: _____

Where was it done? _____