Health History Form

Acct #: _____

Patient Name: _____ **DOB:** _____

Primary Care doctor: _____ **Referring physician:** _____

Pharmacy name, City and State: (local not mail): _____

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

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

10. _____ 11. _____ 12. _____

13. _____ 14. _____ 15. _____

Allergies (include all medication) ***Circle if any allergy to tape, latex and adhesive***

_____

*****Medical History (Please circle and/or list all that you are currently or have been previously treated)*****

Cancer active/previous: _____ Treated with: Chemo and/or Radiation

Allergies	Diabetes type I or II	Kidney disease
Anxiety / Depression	Ear infections	Liver disease
Arthritis / osteo / rheumatoid	GERD	Lyme disease
Asthma/COPD	Glaucoma	Migraines
Atrial Fibrillation	Heart Attack	Nasal trauma
Bleeding disorders: _____	High blood pressure	Sleep Apnea (CPAP)
Congestive heart failure	Hypothyroidism	Stroke (CVA or TIA)
Coronary artery disease (cholesterol etc)	Hyperthyroidism	Thyroid nodules

Please list any other medical conditions/history not listed above: _____

_____

Please list all surgeries: _____

_____

Flu Shot and what year: Yes/No _____ **Pneumonia shot and year:** Yes/No _____

List any family history: (ie: *Cancer, Hearing loss or Thyroid Disorders)*

Mother: _____ Father: _____

Siblings: _____ Grandparents: _____

Social History (Please circle all that apply):

Current: ❑ Smoking ❑ Smokeless tobacco ❑ Cigars ❑ Vaping

Past: ❑ Smoking ❑ Smokeless tobacco ❑ Cigars ❑ Vaping