Please complete and bring with you to your appointment

HEALTH HISTORY

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Who (MD) referred you to us? _____

Why are we seeing you? _____

_____

Symptoms: List symptoms you have or have had in the last year

_____

_____

_____

_____

_____

_____

_____

List all medical conditions/problems

Year	***Medical Condition/Disease***

List all previous surgeries

Year	***Surgical Procedure***

Psychiatric History

_____

_____

_____ Suicide Attempt: Yes / No

Allergies to medications? If yes, please list below:

_____

_____

_____

Please list all your non-prescription / herbal / nutritional supplements

Name of Drug	***Dosage***	***How Often***

Please list all your prescription medications

Name of Drug	***Dosage***	***How Often***

Have you had a blood transfusion? Yes / No If yes, when? _____

Previous Immunizations:

Hepatitis A? Yes / No If yes, when? _____

Hepatitis B? Yes / No If yes, when? _____

Other risk factors for Hepatitis C / Hepatitis B Infection—Please circle all that apply

Tattoos Body Piercing Incarceration

Military Service Medical Care Outside of the US

Blood Transfusion prior to 1992 Dialysis (If yes, year started _____)

SOCIAL HISTORY

Single ☐ Married ☐ (if yes, how many times? _____) Divorce ☐ Widow(ed) ☐

Your highest level of education _____

Your occupation _____

Spouse's education _____

Spouse's occupation _____

Religious preference _____

Any pets at home? Yes / No If yes, how many? _____ Type(s) _____

Family History

Relationship	*Current Age*	*Medical Conditions*	*Age at Death* *(if applicable)*	*Cause of Death* *(if applicable)*
Mother				
Father				
Sisters				
Brothers				
Children				

Alcohol, Drug and Tobacco History

At what age did you have your first drink of beer, wine or alcohol? _____

How often and how much beer, wine or alcohol do you drink? _____

What do you usually drink? _____

What is your peak consumption of beer, wine or alcohol? _____ a day for _____ years.

When was your last drink of beer, wine or alcohol? _____

History of:

Delirium and tremors? Yes / No

Drivng under influence? Yes / No

Job problems? Yes / No

Withdrawl seizures? Yes / No

History of detox or treatment for chemical dependency? Yes / No

If yes, when and where? _____

Have you attended AA or NA meetings? Yes / No If yes, when? _____

Have you ever used illegal IV drugs? Yes / No

Have you ever snorted drugs? Yes / No

If you have ever used any illegal drugs, list the drugs you used and how many years you used them

_____

_____

_____

When was the last time you used an illegal drug and what was it?

_____

_____

Are you now or have you been a smoker? Yes / No

If yes, how long?_____ How much? _____ and date quit _____

Reviewed by: _____

Date / Time: _____