

Health History Form

Name: _____ Preferred name: _____ Birth date: _____

Medical conditions (current and previous)	Age/date diagnosed

Allergies (or sensitivities) to medications or other substances? If so, list with type of reaction:

Current medications and dosages (include over the counter medications):

Vitamins, supplements, herbal remedies:

Surgeries / hospitalizations (include year and reason)

Family history

Medical conditions or cancers / If deceased: age & cause of death

Mother	
Father	
Brothers / sisters	
Maternal grandmother	
Maternal grandfather	
Paternal grandmother	
Paternal grandfather	

(over)

Social history:

Who lives in your household? (please list ages and relationship to you) _____

How long have you lived in Arizona? _____

Occupation _____

Outside interests / hobbies _____

Health habits:

Tobacco:

circle one

Do you currently smoke or chew tobacco? Yes No

Did you ever smoke or chew tobacco? Yes No

If yes, when did you start? _____ How much did you smoke? _____ If you quit, when? _____

Alcohol:

Do you drink alcohol? Yes No

If yes, how many drinks during a typical week? _____

Substance abuse:

Have you been treated for abuse of alcohol, prescription drugs, or street drugs? Yes No

Do you currently use non-prescribed medications or street drugs? Yes No

Seat belts:

Do you use a seat belt? Yes No

Exercise:

Outside of work, do you engage in physical activity on a regular basis? Yes No

If yes, how many days during a typical week do you exercise? _____

On a typical exercise day, how many minutes do you exercise? _____

Health Maintenance:

When was your last physical exam? _____

Tetanus- date of last booster? _____

Pneumonia vaccine (pneumovax) Yes [] No [] If yes, date? _____

Women: last PAP smear? _____ last mammogram? _____

Please list names of other physicians/specialists you currently see, and conditions they treat you for:

Do you have an Advance Directive (living will) in place? Yes [] No []

Do you have a medical power of attorney? If so, please list name here _____

Signature of person who completed this form _____

Printed name _____ Date completed _____

Physician signature _____ Date reviewed _____