HEALTH HISTORY

Name_____ **Date of Birth**_____

MAIN PROBLEMS 1)_____ **2)**_____
3)_____

PATIENT / FAMILY HISTORY: CHECK: P=PATIENT IF=IMMEDIATE FAMILY ( ) NONE

CANCER		MITRAL VALVE PROLAPSE		KIDNEY/BLADDER DISEASES	
DIABETES		HEPATITIS		*STONES	
HYPERTENSION		ANEMIA		*DIFFICULTY WITH URINATION	
STROKE		*CLOTTING DISORDERS		GLAUCOMA	
HEART DISEASES		SEIZURES		RECENT EXPOSURE TO COMMUNICABLE DISEASE	
*HEART FAILURE		SEXUALLY TRANSMITTED DISEASES		*CHICKEN POX	
*HEART ATTACK		BACK / HIP / KNEE PROBLEMS		*TUBERCULOSIS	
RESPIRATORY DISEASES		THYROID DISEASE		MENTAL ILLNESS	
*ASTHMA		IMPLANTS (i.e.PACEMAKERS)		DEMENTIA	
*EMPHYSEMA		*MANUF.#		OTHER:	
*SHORTNESS OF BREATH		VENOUS ACCESS			
		*TYPE			

PREVIOUS HOSPITALIZATION / SURGICAL PROCEDURES

DATE	REASON	DATE	REASON

CURRENT MEDICATIONS ALLERGIES:

NAME	DOSE	FREQUENCY	LAST TAKEN

ARE IMMUNIZATIONS UP TO DATE: ( ) YES ( ) NO ( ) UNKNOWN LAST TETANUS:_____

DATE OF LAST: PAP_____ **MAMMOGRAM**_____ **DEXA SCAN**_____

MENSTRUAL PERIOD_____