JennieStuart
Medical Group

Health History Form

Please complete to the best of your ability.

Date: _____

Name: _____ Date of Birth: _____
Date of last complete physical: _____ Last blood work: _____
Pharmacy _____ Primary Care Physician _____

Allergies to Medication – Include type of reaction.

_____

Medications – *List all current medications and dose*. Include over the counter and herbal medications.

_____
_____
_____

Obstetrics and Gynecological History (Women Only)

Last PAP Smear Date: _____ Abnormal: Yes / No
Last Mammogram Date: _____ Abnormal: Yes / No
Last Bone Density Scan Date: _____ Abnormal: Yes / No
Age of first menstrual period: ____ Date of last menstrual period or age of menopause: ____
Number of pregnancies: ____ Live Births: ___ Miscarriages: ____ Abortions: ____
Cesarean sections: ____ How many? ____ Are you currently pregnant? Yes / No Weeks: _____
Do you have any of the following?

____ Bleeding between periods ____ Heavy periods ____ Extreme menstrual pain
____ Vaginal itching ____ Hot flashes ____ Breast lump
____ Nipple discharge ____ Other: _____

Family History – Please check if your parents, siblings, or grandparents have or have had the following

____ Stroke _____ ____ Seizure Disorder _____
____ Alzheimer's Disease _____ ____ Leukemia _____
____ Thyroid Disease _____ ____ High Blood Pressure _____
____ Tuberculosis _____ ____ Diabetes _____
____ Heart Attack _____ ____ Kidney Disease _____
____ Cancer (please specify location) _____
Other: _____
_____

Social History

__ Married __ Single __Widowed __ Divorced
Occupation _____ Employer _____
Do you smoke? Yes / No | If so: Cigarettes / Pipes / Cigars
How long have you smoked? _____ | How much? _____
Have you quit smoking? Yes / No | How long ago? _____ | Do you want to quit? _____
Do you drink alcohol? Yes / No | Please list amount? _____ | How long? _____
Any illicit drug use? Yes / No | If so, what type? _____ | How long? _____
Do you have: (please circle and provide copy) ***Living Will*** ***Advanced Directive*** ***Power of Attorney***

Past Medical History – Have you had any of the following illnesses?

___ ADD/ADHD	___ Blood Disease	___ Enlarged Prostate	___ High Cholesterol
___ Allergies	___ Chicken Pox	___ Eye/Vision Problems	___ HIV/AIDS
___ Anemia	___ COPD	___ Fibromyalgia	___ High Blood Pressure
___ Angina/Heart Attack	___ Crohn's Disease	___ Gallbladder Disease	___ IBS/Colitis
___ Anxiety/Depression	___ Deep Vein Thrombosis	___ GERD/Reflux	___ Infertility
___ Asthma	___ Diabetes Type ___	___ Gout	___ Jaundice
___ Autoimmune Disease	___ Diverticulitis	___ Heart Disease	___ Kidney Disease
___ Bladder Infection	___ Ear/Hearing Problems	___ Hemorrhoids	___ Kidney Stone

Past Medical History continued

___ Low Back Pain ___ Ovarian cyst
___ Lung Disease ___ Pancreatitis
___ Migraines ___ Seizures/Epilepsy ___ Thyroid Disease
___ Morbid Obesity ___ Sleep Apnea ___ Tuberculosis
___ Organ Transplant ___ Stomach Ulcers ___ Ulcerative Colitis
___ Osteoporosis ___ Stroke ___ Developmental or Behavioral Problems
___ Muscle, Joint or Bone Problems ___ Skin Problems _____
___ Respiratory Problems (specify) _____
___ Cancer (location) _____
Other: _____

Have you or a family member ever had any trouble with anesthesia? Yes / No

Past Surgical History – List date & type of operation(s)

_____

_____

_____

History of Present Illness

Please explain your problem in one sentence: _____

Work Related? Yes / No Employer Name: _____

Where is your problem located? Right / Left Location _____

When did your problem start? _____

Severity of pain on a scale of 1 – 10 1 – Minimal 1 – Severe _____

What else do you experience? __ Swelling __ Grinding __ Give way __ Catching __ Popping __ Locking __ Sleeping Problems

Does the condition affect your ability to work? Yes / No _____

(Occupation)

How? _____ __ Medical Leave __ Light Duty __ Full Duty

Have you previously had this or a similar problem? Yes / No _____

Did you improve? Yes / No _____

Why? _____

What previous treatment have you had for this problem?

__ Surgery __ PT/OT __ Injections __ Braces/Straps __ Casting __ Chiropractor __ Medicine _____

Please list doctors who have treated you for this particular problem:

_____

(Name) (Specialty) (City) (Date)

Have you had:	When?	Where?	Study Here	Report Here
__ X-Ray				
__ MRI				
__ Bone Scan				
__ CT				