ADVANCED FAMILY MEDICINE

HEALTH HISTORY

ALL INFORMATION PROVIDED ON THIS FORM IS RESPECTED AS CONFIDENTIAL

Name:	Today's Date:
Date of Birth:	Employer:
Number of people in household:	Ages of children in household:

Please provide a brief list of any health concerns you would like to discuss today in order of importance to you:

PAST MEDICAL HISTORY

Major illnesses, injuries or hospitalizations (ie. diabetes, heart disease, cancer)	Surgeries (provide type of surgery & year performed)

CURRENT MEDICATIONS (PRESCRIPTION & NON-PRESCRIPTION) **provide names & dosing information**

ALLERGIES TO MEDICATIONS **(list any reactions you have had to medications - for example penicillin or sulfa)**

Have you ever had a tuberculosis test?	YES NO	If yes, give date & results:
Have you ever had a blood transfusion?	YES NO	If yes, give date:

IMMUNIZATIONS (please circle immunizations you have recieved and give the most recent date)

Tetanus	
Influenza	
Pneumovax	

FAMILY MEDICAL HISTORY (If any of the following apply please explain how the family member is related to you)

Alcohol Addiction:	Allergy Rhinitis:
Drug Addiction:	Asthma:
Bleeding Disorder:	Cancer:
Heart Disease:	Diabetes:
Hypertension:	Glaucoma:
Low Thyroid:	Other:
Mental Illness:	Other:
Stroke:	Other:

CURRENT HEALTH PRACTICES - For Adults Only

Do you exercise regularly?	YES NO	If yes, what types of exercise:
Do you have any nutrition or diet concerns you would like help with?	YES NO	If so, please list here:
Which word best describes your seatbelt use?	(please circle)	ALWAYS SOMETIMES NEVER
Do you have an advanced directive or living will?	YES NO	If no, might you be interested in one?
Have you ever used tobacco products regularly?	YES NO	If yes, what tobacco product(s)?
If you answered yes regarding tobacco use at what age did you start using?		How long did you or have you used?
Are you still using tobacco products?	YES NO	Average amount per day?
Have you ever used street/recreational drugs?	YES NO	If yes, what drugs?
If you answered yes regarding drug use at what age did you start using?		How long did you or have you used?
Are you still using drugs?	YES NO	
Do you consume alcohol on a regular basis?	YES NO	What is your preferred type of alcohol?
Has anyone, including your family, ever said that drinking might be causing problems in your life?	YES NO	How much coffee or tea do you drink per day?
Do you think you need to cut back on drinking	YES NO	How much soda do you drink per day?

Patients Name / Responsible Party: (please print)_____

Patient Signature: _____ Date: _____