# PERSONAL HEALTH HISTORY

Please complete the following history form. If you have any questions leave it blank and allow the nurse to assist you. Some of the questions are personal. Please be assured that all information is strictly confidential. Please be as accurate and brief as possible.

NAME ______________________________

| YOU YES | YOU NO | Condition | FAMILY MEMBERS - which member YES | NO |
|---|---|---|---|---|
| ☐ | ☐ | 1. Kidney Disease | ☐ | ☐ |
| ☐ | ☐ | 2. Anemia | ☐ | ☐ |
| ☐ | ☐ | 3. Heart Attack | ☐ | ☐ |
| ☐ | ☐ | 4. Stroke | ☐ | ☐ |
| ☐ | ☐ | 5. High Blood Pressure | ☐ | ☐ |
| ☐ | ☐ | 6. Diabetes | ☐ | ☐ |
| ☐ | ☐ | 7. Gout | ☐ | ☐ |
| ☐ | ☐ | 8. Asthma | ☐ | ☐ |
| ☐ | ☐ | 9. Hay Fever | ☐ | ☐ |
| ☐ | ☐ | 10. Cancer (If yes-where?) | ☐ | ☐ |
| ☐ | ☐ | 11. Fits, Seizures, Convulsions | ☐ | ☐ |
| ☐ | ☐ | 12. Birth Defects | ☐ | ☐ |
| ☐ | ☐ | 13. Mental Illness (What Kind?) | ☐ | ☐ |
| ☐ | ☐ | 14. Bleeding Problems | ☐ | ☐ |
| ☐ | ☐ | 15. Hepatitis | ☐ | ☐ |
| ☐ | ☐ | 16. Rheumatic Fever | ☐ | ☐ |
| ☐ | ☐ | 17. Syphillis, Gonorrhea | ☐ | ☐ |
| ☐ | ☐ | 18. German Measles | ☐ | ☐ |

ARE YOU ALLERGIC TO ANY MEDICINES? (What kind of reaction?) ______________________________

Do you smoke cigarettes/pipe/cigars? (If yes, how many packs/day?) ______________

Age when started? ______________

Do you drink alcohol? never/rarely/occasionally/moderately/heavily? ______________

Have you ever used recreational drugs? ______________

Have you ever been in the hospital overnight? If yes - why? ______________

Have you ever had any surgery or illness not mentioned above? ______________

Is your father living? If no - what was age and cause of death? ______________

Is your mother living? If no - what was age and cause of death? ______________

How many sisters _______ and brothers _______ do you have?

PRESCRIBED MEDICATIONS TAKEN REGULARLY:

| NAME OF DRUG | DOSAGES | TIMES A DAY TAKEN |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

When was your last FLU SHOT? _________, TETANUS _________, PNEUMOVAX _________

FOR FEMALE ONLY

Age when period began? _________ Are your periods regular? _________

Do you have any problems with your periods? _________ When was your last period? _________ (mo. da. yr.)

Have you ever had a hysterectomy? If yes - when was it? _________

Why was this surgery done? _________ Were both ovaries removed? _________

When was your last pap smear? _________ Was it normal?

Have you ever been pregnant before? If yes - how many pregnancies? _________

How many deliveries? _________ Any miscarriages? _____ How many?

Any abortions? _____ How many?

Do you use any birth control? _________ What kind?