

History Intake Form

Health History

Patient Name: _____ **Age:** _____ **Birthdate:** _____

Please answer all of the questions as accurately as possible. If you do not understand the question please ask for assistance.

Reason for today's visit: _____

Primary Care Doctor: _____

Smoking (type & amount per day) _____ Alcohol (type & amount per day) _____

If former smoker, date quit _____ Weight _____ Height _____

Drug allergies: _____

List previous surgeries (Cosmetic and medical) or major illnesses and dates:

List any medications you are taking, including non-prescription drugs, vitamins, and herbals:

Family History:

Has any blood relative ever had the following:

Breast Cancer.....no yes	Melanoma..... no yes	Stroke..... no yes
High blood pressure.....no yes	Heart Disease..... no yes	Diabetes..... no yes
Kidney disease.....no yes	Depression..... no yes	

Past Medical History:

Have you ever had the following:

Heart disease.....no yes	Arthritis..... no yes	Rheumatic Fever..... no yes
Cancer.....no yes	Glaucoma..... no yes	Asthma no yes
Stomach Ulcer.....no yes	Kidney disease..... no yes	Thyroid disease..... no yes
Anemia.....no yes	Tuberculosis no yes	Diabetes..... no yes
AIDS or HIV.....no yes	Stroke..... no yes	Hepatitis..... no yes
Bleeding tendency..... no yes	Mitral Valve Prolapse..... no yes	High blood pressure..... no yes

Review of Systems:

Do you have or have had within the past year:

Weight Change..... no yes	Dry eyes..... no yes	Chronic Cough no yes
Swollen feet/ankles no yes	Skin rash. no yes	Chronic Diarrhea no yes
Seizures.....no yes	Joint/Muscle pain..... no yes	Swollen lymph nodes..... no yes
Chest pain.....no yes	Depression..... no yes	Easy bleeding..... no yes
Jaundice no yes	Easy bruising..... no yes	Rapid heart beat..... no yes

Women only:

Age period began _____

of Pregnancies _____

Date of last mammogram _____

Did you breastfeed?..... no yes

Do you do regular breast self-examinations?... no yes

Breast lump or discharge ... no yes

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. THIS FORM MUST BE COMPLETED BEFORE SEEING THE DOCTOR.

X _____
Signature of patient or parent if minor

Date