

First Name:	Middle Name:	Last Name:
Nickname:	Best Phone # for Contact:	Date of Birth:

Race: Caucasian Black Asian Other _____ **Ethnicity:** Hispanic Non Hispanic Decline

Language: _____ **Marital Status:** Single Married Needs Work Separated Divorced Widowed

List all doctors seen in the past 2 years: _____

Which pharmacy do you use? _____ **Location:** _____ **Phone #** _____

List Drug Allergies: None _____

PLEASE DO YOUR BEST TO ANSWER EVERYTHING COMPLETELY. It's not just us being nosy – the majority of these questions are required by your insurance. We promise – this information is only available to the medical staff here and to your insurance company IF they review your chart. Please Answer ALL Questions ... CIRCLE THE BEST ANSWER!

Highest Level of School: Student or Finished Grade ____ High School 2yr College 4yr College Degree: ____

I work: Full time Part time Job Hunter On Unemployment Retired Disabled

Describe your job and do you like it? _____

Tobacco:	YES NO	¼ ½ ¾ 1 pk more Daily	Since Age:	Yr. Quit:	Ready to quit?
Drinker:	YES NO	# per day: # per wk:	Beer Wine Liquor	Is it a problem?	
Smoke Marijuana:	YES NO PAST	Illegal Drug Use: YES NO PAST			
Victim of Physical / Verbal Abuse:	YES NO SOMETIMES PAST	Addiction: YES NO PAST			

I would say my sleep is:	ENOUGH NOT ENOUGH TROUBLED	# HRS PER NIGHT:
I would say I am depressed:	FREQUENTLY USUALLY DEPENDS ON THE DAY NEVER	
My energy level is:	GREAT GOOD ENOUGH COULD BE BETTER WHAT ENERGY?	
Exercise:	DON'T ASK I do ____ x wk I do ____ x month What activities?	

I get Headaches:	NO SOMETIMES DAILY WEEKLY MONTHLY What helps?
I wear Glasses / Contacts:	YES NO For READING For DRIVING LAST EYE EXAM:
I have Hearing Loss:	NO RIGHT LEFT BOTH Wear Seat Belts: ALWAYS USUALLY NEVER
Smoke/Fire Alarms:	GOT IT NEED TO GET IT Firearms: NOPE YUP UNLOADED IN LOCK BOX

I take my meds:	NO MEDS ALL THE TIME USUALLY SOMETIMES WHEN I CAN AFFORD IT
Medicines I take: (include over the counter & vitamins)	Hospitalizations / Procedures & Year:

Chart: _____ **DATE:** _____

If YES, CHECK the box for yourself or for the family member who has or had any of the problems listed:									
Medical Condition	Me Never	Me Past	Me Now	My Mom	My Dad	My Sister	My Brother	My Kids	My Grandparent
ADHD									
Alcoholism									
Allergies									
Anemia									
Arthritis									
Anxiety									
Asthma									
Birth Defects									
Bipolar Disorder									
Cancer									
Constipation									
Diabetes									
Depression									
Drug Use									
Lung Issues									
Gout									
Hearing Loss									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Irritable Bowel									
Insomnia									
Kidney Problems									
Liver Disease									
Migraines									
Obesity									
Pain Medicines									
Stroke									
Thyroid problem									
Vision Loss									

MEN ONLY:

Testicular Pain: YES NO **Urinary Problems:** YES NO **Erectile Dysfunction:** NEVER SOMETIMES ALWAYS
STD: YES NO PAST **Sexually Active:** YES NO I Wish Don't enjoy it Less than I'd Like No Chance

WOMEN ONLY:

Last Pap Date: _____ **Last Mammogram:** _____ **Need Pap:** YES NO **Need Mammo:** YES NO
Sexually active: YES NO I Wish Don't enjoy it Less than I'd Like No Chance
Of PREGNANCIES: _____ **# OF MISCARRIGES:** _____ **# OF ABORTIONS:** _____ **Birth Control:** _____
Vaginal itching: YES NO **Burning:** YES NO **Period started at age:** _____ **Still have it?** _____

Issues I worry about: _____

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

The Information on this Patient Health History Form is correct to the best of my knowledge. I will inform the staff of any changes.