PERSONAL HEALTH HISTORY

Patient: _____ _____ _____ DOB: _____
Last name First Name Middle Name

What is the main reason for your visit to our clinic today? _____

Please circle which apply: **Do you drink?** Yes or No **Do you smoke?** Yes or No

Allergies: Do you have any allergies to the following? **(Please select all that apply)**

- ☐ Sulfa
- ☐ NSAIDS
- ☐ Penicillin
- ☐ Latex
- ☐ Tetracycline
- ☐ Lidocaine
- ☐ Morphine
- ☐ Aspirin
- ☐ Sulfites
- ☐ Codeine
- ☐ Iodine
- ☐ Myocin

Other: _____

Local pharmacy: _____

Medications: List all medications, over the counter medications, vitamins, or other supplements you are taking:

Name of Medication/Supplement	Strength	Frequency Taken

Medical Conditions: Do you currently have or have a history of the following? **(Please select all that apply)**

- ☐ Heart Disease
- ☐ Asthma
- ☐ Depression/Anxiety
- ☐ Stomach Ulcer
- ☐ High Blood Pressure
- ☐ COPD
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Colitis
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Stroke
- ☐ Cancer
- ☐ Thyroid Disorder

Surgeries/Hospitalizations:

- ☐ Appendectomy
- ☐ CABG
- ☐ Tonsillectomy
- ☐ C-Section
- ☐ Cholecystectomy
- ☐ Colon Surgery
- ☐ Prostate Surgery
- ☐ Valve Replacement
- ☐ Hernia Surgery
- ☐ Small Intestine Surgery
- ☐ Peritoneal Dialysis

Other: _____

Family History: _____