

HEALTH SUMMARY

Patient Name: _____

Date: _____

Birth Date: ___ / ___ / ___

Height: _____ Weight: _____ lb.

Yes No

Do you have any allergies? If yes please list

What pharmacy do you use: _____

Address: _____ City: _____ State: _____

Yes No

Medications? If yes what medications are you taking (including birth control pills, herbals, vitamins, dietary supplements and over the counter?)

Present Health Conditions

Yes	No	Disease
		Irregular Heart Beat
		Congestive Heart Failure
		Heart Attack
		Heart Murmur
		Rheumatic Fever
		High Cholesterol
		High Blood Pressure
		Asthma
		Emphysema/Chronic Bronchitis
		Blood Clot Lung
		Blood Clot Leg
		Tuberculosis
		Gallstones
		Liver Disease, Type: _____
		Ulcers in Bowels/Stomach
		Bleeding from Bowels
		Kidney Disease, Type: _____
		Kidney Stones

Yes	No	Disease
		Prostate Problems
		Gout
		Arthritis
		Skin Disease, Type: _____
		Stroke
		Epilepsy/Seizures
		Diabetes/High Blood Sugar
		Thyroid Problems, Too High Too Low
		Anemia/Low Blood
		Bleeding Problems, Type: _____
		Blood Transfusion
		Cancer, Type: _____
		Anxiety
		Depression
		Glaucoma
		Other: _____

Surgeries

Yes	No	Surgery
		Cataract Surgery <input type="checkbox"/> Left <input type="checkbox"/> Right
		Tonsils Removed
		Neck Artery Surgery
		Open Heart Surgery/Catheterization
		Appendectomy
		Gallbladder Removal
		Abdominal Surgery
		Broken Bone Repair
		Joint Scope Surgery

Yes	No	Surgery
		Joint Replacement of Hip/Knee
		Back Disc Surgery
		Prostate Surgery
		Hernia Surgery
		Vasectomy
		Hysterectomy
		Other: _____

HEALTH SUMMARY CONTINUED

Family History			
Yes	No	Disease	Relationship to you
		Heart Attack	
		High Blood Pressure	
		High Cholesterol	
		Asthma	
		Tuberculosis	
		Liver Disease	
		Kidney Disease	
		Gout/Arthritis	
		Osteoporosis	
		Stroke	
		Epilepsy/Seizures	
		Anxiety or Depression	

Yes	No	Disease	Relationship to you
		Bleeding Problems	
		Sickle Cell Anemia	
		Diabetes/ High Blood Sugar	
		Thyroid Problems	
		Cancer Type: _____	
		Alcohol Abuse	
		Glaucoma	
		Other: _____	_____
		_____	_____
		_____	_____

Other History

Exercise: Never Rarely Other: _____

When was your last:

Tetanus: _____ Never Pneumovax: _____ Never

Hepatitis B: _____ Never Flu Shot: _____ Never

Smoking:

Yes No
 Have you ever smoked How many years did you smoke? _____
 Do you use smokeless tobacco? When did you quit? _____
 How many packs per day do you smoke now? _____

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol/Drugs

Yes No
 Do you drink? How much? _____ How Often? _____
 Do you use drugs? How much? _____ How Often? _____ What kind? _____
 What Drugs have you used in the past? _____

The above information is current and correct to the best of my knowledge.

I have reviewed the above history

 Patient / Guardian Signature

 Date

 Physician's Initial

 Date