WESTCHASE HEALTH CLINIC

HEALTH HISTORY

MR#: _____
Name: _____ Date of birth: _____
Last First Middle Initial Age: _____
SSN: _____ - ____- _____ Home phone :(_____) _____ Gender: M _____ F _____

What is the reason for your office visit today? _____
_____

PAST MEDICAL HISTORY (List all diseases, conditions with year of onset
_____
_____
_____

PASTSURGICALHISTORY(with year of surgery and dates of hospitalizations)
_____
_____

MEDICATIONS (List all meds, strength & frequency, include non-prescriptions & herbs/supplements as well)
_____
_____
_____

ALLERGIES (List all medications, foods or agents & the reaction) No Allergies: _____
_____
_____

SOCIAL HISTORY:

Tobacco:	Current use:_____	How much?	_____pack/day	Duration:_____ mth /years
	Past use: _____	How much?	_____pack/day	Duration:_____ mth /years
	Quit Date:_____			
Alcohol:	Current use:_____	How much?	_____day/wk	Duration:_____
	Past use: _____	How much?	_____day/wk	Duration:_____
	Quit Date: _____			

Exercise: Yes____ No___ Type:_____ How long?_____ Frequency _____
Diet: _____Occupation: _____
Sexual activity: Yes_____ No_____ Any history of sexually transmitted disease? _____
When? _____ Was it treated? _____

FAMILY HISTORY:
Indicate if any immediate family members have the following conditions or diseases:

____ Alzheimer's disease	____ Diabetes	____ Osteoporosis	____ Breast or Ovary cancer
____ Anemia	____ Hypertension	____ Prostate Cancer	____ Prostrate Cancer
____ Bleeding Disorder	____ Thyroid Disease	____ Stomach or Colon Cancer	
____ Breast Cancer	____ Melanoma	____Early Heart attack / coronary artery disease	

IMMUNIZATION HISTORY:
When was your most recent?
Tetanus Shot (Td) / DTap: _____ Hepatitis B: _____ Pneumococcal Vaccine: _____ Flu: _____

PAST PREVENTIVE CARE:
When was your most recent?

Annual Physical Exam: _____	Well Woman Exam: _____	Eye Exam: _____
Mammogram: _____	Bone Density Test: _____	PSA/Prostate Screen:_____
Colonoscopy / Sigmoidoscopy: _____	EKG: _____	

Do you have a Living Will or Durable Power of Attorney for healthcare? _____ Yes _____ No

Patient Signature: _____ Date: _____

Physician Comments: