Health History Form

Patient Information *(Please Print)*

Name (First, MI, Last): ______________________ Sex: ☐ Female ☐ Male ☐ Other

Birth Date: ______/_______/_______ Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed

Primary Physician Name: ______________________ Facility: ______________________

Preferred Pharmacy Name: ______________________ City: ______________________

Employer: ______________________ Position: ______________________

Are any of the following concerns in your health?

☐ Weight Change ☐ Energy Level ☐ Sleep Issues ☐ Anxiety ☐ Depression

☐ Hormone Issues ☐ Pain/Discomfort ☐ Headaches ☐ Skin Problems ☐ Other ______________

Personal History

Have you been diagnosed with a medical condition by another physician? ☐ No ☐ Yes, please list:

Medical Condition	When

Have you had any past surgeries? ☐ No ☐ Yes, please list:

Surgery	When

Have you ever been hospitalized? ☐ No ☐ Yes, please list:

Hospitalized	When

Do you have any implantable devices? ☐ No ☐ Yes, please list:

Device	When

Please list all Medications & Supplements

Name	Strength	Frequency Taken

Do you have any allergies to medications? ☐ No ☐ Yes; If yes, to what? ____________________

Do you have any other allergies? ☐ No ☐ Yes; If yes, to what? ____________________

Family History

Please list any health problems for the following family members; Mother, Father, Siblings, Grandparents.

Who	Age	Health Problems	Alive
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No

Social History

Do you smoke tobacco? ☐ Never ☐ Former ☐ Yes; If yes, how many per day? __________ Per week? ______________

Do you use other forms of tobacco? ☐ Chew ☐ Pipe ☐ Cigars ☐ Vape

Do you drink alcohol? ☐ No ☐ Yes; If yes, how many drinks per day? ______________ Per week? ______________

Do you use recreational or street drugs? ☐ No ☐ Yes; If yes, have you ever given yourself street drugs with a needle? __________

Do you exercise? ☐ No ☐ Mild Exercise (Walking, Climb Stairs) ☐ Occasional Exercise (Less than 4x/week) ☐ Frequently

Are you on a special diet? ☐ No ☐ Yes; If yes, what type? ____________________

How often do you eat healthy meals? ☐ Never ☐ Occasionally ☐ Regularly; How many meals do you eat in a day? _______

Do you drink caffeine? ☐ No ☐ Coffee ☐ Soda; How many cups/cans per day? ____________________

Are you sexually active? ☐ No ☐ Yes; Do you practice safe sex? ☐ No ☐ Yes; If no, are you trying to conceive? ☐ No ☐ Yes

Mental Health

Is stress a major problem for you? ☐ No ☐ Yes; Do you panic when you are stressed? ☐ No ☐ Yes

Do you feel depressed? ☐ No ☐ Yes; Do you cry frequently? ☐ No ☐ Yes

Have you ever attempted or thought about hurting yourself? ☐ No ☐ Yes; About Suicide? ☐ No ☐ Yes

Do you have trouble sleeping? ☐ No ☐ Yes; If yes, how? ____________________

Do you have problems with eating or your appetite? ☐ No ☐ Yes; Have you ever had an eating disorder? ☐ No ☐ Yes

Have you ever been to a counselor? ☐ No ☐ Yes

Women Only

How old were you when you started your menstrual cycle? ____________________

When was the first day of your last cycle? ____________________ How long does it last? ____________________

Do you have heavy, irregular, or painful menstrual cycles? ☐ No ☐ Yes

Home many times have you been pregnant? ____________________ How many live births? __________ C-Sections? __________

Are your currently pregnant or breast feeding? ☐ No ☐ Yes

Have you had a D&C or hysterectomy? ☐ No ☐ Yes

Have you had UTI, bladder, or kidney infections in the last year? ☐ No ☐ Yes

Any blood in your urine? ☐ No ☐ Yes; Any problems with controlling your urination? ☐ No ☐ Yes

Have you had extra discharge or yeast infections in the last year? ☐ No ☐ Yes

Do you have hot flashes or sweating at night? ☐ No ☐ Yes

Have you recently experiences breast tenderness, lumps, or nipple discharge? ☐ No ☐ Yes

When was your last pap exam? ____________________

Men Only

Do you usually get up to urinate during the night? ☐ No ☐ Yes If yes, how many times? ______________

Do you feel pain or burning with urination? ☐ No ☐ Yes; Any blood in the urine? ☐ No ☐ Yes

Do you feel burning discharge from your penis? ☐ No ☐ Yes

Do you have any problems emptying your bladder completely? ☐ No ☐ Yes;

Has the force of your urination decreased? ☐ No ☐ Yes

Do you have any problems emptying your bladder completely? ☐ No ☐ Yes

Have you had any kidney, bladder, or prostate infections within the last year? ☐ No ☐ Yes

Do you have any problems emptying your bladder completely? ☐ No ☐ Yes

Any difficulty with erection or ejaculations? ☐ No ☐ Yes; Any testicle pain or swelling? ☐ No ☐ Yes

When was your last prostate exam? ____________________