



# Health History

Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Chart # \_\_\_\_\_

Appointment date \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender:  Male  Female  Transgender

Reason for today's visit \_\_\_\_\_

### Medications

Please list current medications, including birth control and over the counter medications/supplements \_\_\_\_\_

### Allergies

Drug Allergies  No  Yes (list) \_\_\_\_\_

Latex Allergies  No  Yes  Environmental Allergies (list) \_\_\_\_\_

### Personal and Family History

Have you or any close blood relative had any of the following? If yes, specify relationship (i.e. mother, grandmother, father, etc.)

Self	Family		Self	Family	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion _____	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to second-hand smoke _____
<input type="checkbox"/>	<input type="checkbox"/>	Headaches/migraine _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety _____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia _____	<input type="checkbox"/>	<input type="checkbox"/>	Anemia _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/lung disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems/clots _____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach/digestive disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Bowel/bladder problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to HIV _____			

### Surgical History

Please list procedures and dates \_\_\_\_\_

### Social History

What year are you in school? \_\_\_\_\_ What is your academic major? \_\_\_\_\_

Tobacco use?  Never  Former  Current (use in past month) Type \_\_\_\_\_ Amount \_\_\_\_\_

Do you use alcohol?  Yes  No

If yes, on average, how many days per week do you drink? \_\_\_\_\_

On a typical day when you drink, how many drinks do you have? \_\_\_\_\_

What is the maximum number of drinks you have had on one occasion in the past 30 days? \_\_\_\_\_

Do you use any other drugs (marijuana, cocaine, other)?  Yes  No Daily caffeine intake \_\_\_\_\_

What kind of exercise are you doing? \_\_\_\_\_ Frequency \_\_\_\_\_

### Sexual History

Are you sexually active?  Yes  No Partners are:  Male  Female  Both

Age at onset of sexual activity \_\_\_\_\_ Total number of sexual partners \_\_\_\_\_

Do you use condoms regularly?  Yes  No  Sometimes  What percent of time? \_\_\_\_\_

Have you ever been diagnosed with a sexually transmitted infection?  Yes  No

If yes, what type? \_\_\_\_\_ Treatment \_\_\_\_\_