PATIENT HEALTH HISTORY

Bring this to your appointment

Sample — replace with your own details. Fill every box that applies; leave the rest blank.

YOUR INFORMATION

FULL NAME

DATE OF BIRTH *(MM / DD / YYYY)*

SEX

PHONE

EMAIL

HOME ADDRESS

CARE TEAM

PRIMARY DOCTOR *(name & phone)*

PREFERRED PHARMACY *(name & phone)*

INSURANCE

PROVIDER

MEMBER ID

GROUP #

MEDICAL CONDITIONS

Check any condition you have now or have had in the past.

- ☐ High blood pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Asthma / COPD
- ☐ Thyroid disorder
- ☐ Depression / Anxiety
- ☐ Vision / Hearing loss
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Acid reflux
- ☐ Other

OTHER CONDITIONS *(list anything not above)*

CURRENT MEDICATIONS

List medicines, vitamins and supplements exactly as printed on the bottle (e.g. "Atorvastatin 20 mg").

#	MEDICATION & STRENGTH	DOSE	HOW OFTEN
1			
2			
3			
4			
5			
6			

ALLERGIES

Medicines, foods or other allergies — type "NONE KNOWN" if none.

SURGERIES & HOSPITALIZATIONS

Include the year and the reason, if you remember it.

FAMILY HISTORY

Check any condition that runs in your immediate family (parents, siblings, children).

- ☐ Heart disease
- ☐ Diabetes
- ☐ Cancer

OTHER FAMILY HISTORY *(who & what condition)*

LIFESTYLE

TOBACCO *(never / past / current)*

ALCOHOL *(drinks per week)*

EXERCISE *(days per week)*

EMERGENCY CONTACT

NAME

RELATIONSHIP

PHONE