PERSONAL HISTORY & HEALTH ASSESSMENT

Patient Name: ---------- Date of Birth: ----------

Allergies: ☐ Medicine: ---------- ☐ Food: ----------
☐ Other: ----------

PAST SURGERIES & HOSPITALIZATIONS: ----------

History of Healthcare: (please write dates of last exam)

Eye Exam: ---------- Hearing Exam: ---------- Colonoscopy: ---------- Mammogram: ----------

RISK & PREVENTION: (please check if applicable)	Yes	No
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
Do you use recreational drugs?	☐	☐

MEDICAL CONDITIONS

HEAD, EYES, EARS, NOSE & THROAT
☐ Problems: ----------
☐ Other: ----------

RESPIRATORY
☐ Asthma ☐ COPD/Emphysema
☐ Other: ----------

CARDIOVASCULAR
☐ Heart disease
☐ Pacemaker
☐ Other: ----------

MUSCULOSKELETAL
☐ Gout
☐ Arthritis
☐ Other: ----------

GASTROINTESTINAL
☐ Type of Disease: ----------
☐ Other: ----------

GENITOURINARY
☐ Prostate
☐ Urinary incontinence
☐ Other: ----------

ENDOCRINE
☐ Thyroid disease
☐ Diabetes
☐ Other: ----------

NEURO/PSYCHIATRIC
☐ Seizures ☐ Depression
☐ Anxiety ☐ Stroke
☐ Alzheimers/Dementia

SKIN and HAIR
☐ Skin condition/Cancer: ----------

HEMATOLOGICAL
☐ Anemia ☐ Cancer: ----------

SIGNIFICANT FAMILY HISTORY
☐ Mother: ----------
☐ Father: ----------
☐ G.P: ----------
☐ Siblings: ----------

MEDICATIONS:

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