

# Health History Form

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Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**MEDICAL CONDITIONS (CURRENT AND PREVIOUS):** Age/Date Diagnosed

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**ALLERGIES (OR SENSATIVITIES) TO MEDICATIONS OR OTHER SUBSTANCE:**  
Type of Reaction

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**CURRENT MEDICATIONS AND DOSAGES (INCLUDE OVER THE COUNTER MEDICATIONS):**

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**VITAMINS, SUPPLEMENTS, HERBAL REMEDIES:**

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**SURGERIES/HOSPITALIZATIONS (INCLUDE YEAR AND REASON):**

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**FAMILY HISTORY**    MEDICAL CONDITIONS OR CANCERS/If deceased give age and cause death:

\_\_\_\_\_  
Mother  
\_\_\_\_\_  
Father  
\_\_\_\_\_  
Brothers  
\_\_\_\_\_  
Sisters  
\_\_\_\_\_  
Maternal Grandmother  
\_\_\_\_\_  
Maternal Grandfather  
\_\_\_\_\_  
Paternal Grandmother  
\_\_\_\_\_  
Paternal Grandfather  
\_\_\_\_\_

**Social History:**

Who lives in your household? (please list ages and relationship): \_\_\_\_\_  
\_\_\_\_\_  
How long have you lived in Arizona? \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Outside Interests/Hobbies: \_\_\_\_\_

**Health Habits:**

**Tobacco:**  
Do you currently smoke or chew tobacco? \_\_\_\_\_  
Did you ever smoke or chew tobacco? \_\_\_\_\_  
If yes, when did you start? \_\_\_\_\_ If quit, when? \_\_\_\_\_ How much do/did you smoke? \_\_\_\_\_

**Alcohol:**  
Do you drink alcohol? \_\_\_\_\_  
If yes, how many drinks during a typical week? \_\_\_\_\_

**Substance Abuse:**  
Have you been treated for abuse of alcohol, prescription drugs or street drugs? \_\_\_\_\_  
Do you currently use non-prescribed medications or street drugs? \_\_\_\_\_

**Seat Belts:**  
Do you use a seat belt? \_\_\_\_\_

**Exercise:**  
Outside of work, do you engage in physical activity on a regular basis? \_\_\_\_\_  
If yes, how many days during a typical week do you exercise? \_\_\_\_\_  
On a typical exercise day, how many minutes do you exercise? \_\_\_\_\_

**Health Maintenance:**

When was your last physical exam? \_\_\_\_\_  
Women: Last Pap Smear? \_\_\_\_\_ Last Mammogram? \_\_\_\_\_  
Tetanus-Date of last booster \_\_\_\_\_ Flu Vaccine-Date of last \_\_\_\_\_  
Pneumonia Vaccine-Date of Last \_\_\_\_\_ Zostavax-Date given \_\_\_\_\_  
Other Vaccinations and dates given \_\_\_\_\_

Please list names of other physicians/specialists you are currently seeing and conditions they are treating:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have an Advanced Directive (Living Will) in place:    [ ]NO    [ ]YES

Do you have a Medical Power of Attorney? If yes, please list name(s): \_\_\_\_\_

**SIGNATURE OF PERSON COMPLETING FORM:** \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_