

Date \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

**Check if you have or have ever had any of the following:**

- Abnormal PAP
- Abuse
- AIDS
- Alcoholism/Drug addiction
- Allergies
- Anorexia
- Anxiety
- Arthritis
- Asthma
- Bleeding disorder
- Blood clots to legs or lungs
- Blood transfusion
- Cancer What kind \_\_\_\_\_
- Chicken pox
- Depression
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart disease
- Hepatitis
- High blood pressure
- High cholesterol
- HIV positive
- Liver disease
- Migraines
- Sexually transmitted disease
- Skin disorders
- Stroke
- Suicide attempts
- Thyroid problem
- TB
- Ulcer
- \_\_\_\_\_

**Other serious illnesses or injuries** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES/REACTIONS** \_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**HOSPITALIZATION & SURGERIES**

Year	Hospital	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FAMILY HISTORY**

Relation	Living	Age/ Age at death	Medical Problems
Father	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	_____	_____
Brother	<input type="checkbox"/>	_____	_____
Sister	<input type="checkbox"/>	_____	_____

Check if any blood relative had:  Asthma  Allergies  Cancer  Chemical Dependency  Depression  
 Diabetes  Heart Disease  High Blood Pressure

**SOCIAL HISTORY** (Check if you use)

	How much	Quit when
<input type="checkbox"/> Alcohol	_____	_____
<input type="checkbox"/> Drugs	_____	_____
<input type="checkbox"/> Tobacco	_____	_____

**PREVENTIVE CARE**

	last check up
<input type="checkbox"/> Dental	_____
<input type="checkbox"/> Mammogram	_____
<input type="checkbox"/> PAP	_____
<input type="checkbox"/> Prostate Exam	_____

**IMMUNIZATION HISTORY** (Check if immunized)

<input type="checkbox"/> Flu	Year _____	<input type="checkbox"/> _____	Year _____
<input type="checkbox"/> Hep B	Year _____	<input type="checkbox"/> _____	Year _____
<input type="checkbox"/> Pneumonia	Year _____	<input type="checkbox"/> _____	Year _____
<input type="checkbox"/> TB	Year _____	<input type="checkbox"/> _____	Year _____
<input type="checkbox"/> Tetanus	Year _____	<input type="checkbox"/> _____	Year _____

**MARITAL STATUS**

Married  Divorced  Widow  Single  Separated

Occupation \_\_\_\_\_

Nationality of origin \_\_\_\_\_

Number in household \_\_\_\_\_

**NOTES** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Heart of Ohio Family Health Centers™**

Initial Health History (2 of 2)

NAME

DOB

MR #