



Today's Date \_\_\_\_\_ Patient's Name \_\_\_\_\_ Patient's DOB \_\_\_\_\_

Patient's Primary Care Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

### Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. Please take time to complete this questionnaire before your appointment. **Thank you!**

Main reason for today's visit: \_\_\_\_\_

**REVIEW OF ORGAN SYSTEMS: Please check any current and past problems.**

- |  |  |
|--|--|
| <input type="checkbox"/> Abnormal sense of taste or smell                    | <input type="checkbox"/> High Blood Pressure               |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Immunologic Disease               |
| <input type="checkbox"/> Blood/Bleeding Disorders                            | <input type="checkbox"/> Infections Disease (HIV/TB)       |
| <input type="checkbox"/> Breathing with mouth open at night                  | <input type="checkbox"/> Insect Allergy                    |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Lung Disease                      |
| <input type="checkbox"/> Cough, Wheeze or Shortness of Breath                | <input type="checkbox"/> Neurological Disorder/Seizures    |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Psychological Disorder/Depression |
| <input type="checkbox"/> Dizziness   | <input type="checkbox"/> Skin Disease                      |
| <input type="checkbox"/> Fever   | <input type="checkbox"/> Snoring                           |
| <input type="checkbox"/> Gastrointestinal Disorder, Heartburn or Indigestion | <input type="checkbox"/> Thyroid Disorder                  |
| <input type="checkbox"/> Headaches   | <input type="checkbox"/> Unexplained change in weight      |
| <input type="checkbox"/> Heart Disease                                       |  |

What medications are you taking? (include over-the-counter products, vitamins, birth control, and herbal remedies)

Medication	Dose (e.g., mg/pill)	How many times per day

Pharmacy Name & Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you been hospitalized? Please list approximate dates and reasons:

_____	_____
_____	_____

Have you had surgery? Please list approximate dates and reasons:

_____	_____
_____	_____

Do you have any medication allergies? Yes \_\_\_ No \_\_\_

If YES please list: \_\_\_\_\_

Do you have any food allergies? Are there any foods you suspect? Yes \_\_\_ No \_\_\_

If YES please list: \_\_\_\_\_

**Strauss Allergy and Asthma**

**FAMILY HISTORY (Please indicate family members with any of the following conditions):**

	Mother	Father	Sibling
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic stuffy/runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunologic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ENVIRONMENT:**

Do you have pets at home?    Yes \_\_\_    No \_\_\_

If YES, please circle:    Cat    Dog    Bird    Other \_\_\_\_\_

List Breed: \_\_\_\_\_

Do you smoke?    Yes \_\_\_    No \_\_\_    Have you ever smoked?    Yes \_\_\_    No \_\_\_    Quit Date: \_\_\_\_\_

How many packs per day? \_\_\_\_\_    # of years \_\_\_\_\_

Are there any smokers living in the home?    Yes \_\_\_    No \_\_\_

What type of work do you do? \_\_\_\_\_

Are you exposed to anything at work that you are concerned may affect your health? \_\_\_\_\_

When was your last chest x-ray? (Please list date and where it was done) \_\_\_\_\_

**IMMUNIZATIONS:**

Are the patient's immunizations up to date:    Yes \_\_\_    No \_\_\_

If NO, please explain: \_\_\_\_\_

Did you have the influenza vaccine this year?    Yes \_\_\_    No \_\_\_

Who completed this form? \_\_\_\_\_

Name

Relation

**In Office Use Only:**  
 Reviewed by: \_\_\_\_\_