Date:

HEALTH HISTORY FORM FOR ANNUAL PHYSICAL EXAM

Name *(Last, First, M.I.):* ☐ M ☐ F	**BIRTH DATE:**

PERSONAL HEALTH HISTORY

Current Medical conditions – (list health problems diagnosed by physician for which you are currently taking medications)

Past Surgeries / Hospitalizations

Medication List – (List prescribed drugs and over-the-counter drugs)

Pharmacy name: City where pharmacy is located: Pharmacy phone #

Allergies to medications

Name the specialists that you see along with their specialty below:

What is your profession? _____

☐ Sitting job ☐ Standing job ☐ Involves lifting/ pushing/ pulling weight ☐ Deal with sick people ☐ School ☐ Night shift
☐ Taxi / truck driver ☐ Travelling job ☐ Exposed to dust/ fumes/ pets ☐Other:

HEALTH HABITS AND PERSONAL DETAILS THAT MAY IMPACT YOUR HEALTH

Exercise:	☐ No exercise ☐ Mild exercise ☐ Regular vigorous exercise			**Diet:**	☐ Vegetarian	☐ Non-vegetarian
Alcohol:	Did you ever drink alcohol in life?	☐ Yes	☐ No	**If yes**: ☐ Daily ☐ _____ times per week ☐ Quit date:_____		
Tobacco:	Do you use tobacco?	☐ Yes	☐ No	**If yes**: ☐ ____ cig per day, ☐ ____ chewing per day ☐ Quit date:_____		
Drugs:	Do you currently use recreational or street drugs?			☐ Yes	☐ No	**If yes**: what _____ how many times per week_____
	Have you ever given yourself drugs with a needle?			☐ Yes	☐ No	
Sex:	Have you ever been sexually active?			☐ Yes	☐ No	**If yes**: what is your method of contraception: _____
	Did you ever have Sexually transmitted infection?			☐ Yes	☐ No	**If yes**: what? _____
Personal Safety:	Do you live alone?			☐ Yes	☐ No	
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No	**If yes**: please provide a copy to our office
Do you have pets in the house?				☐ Yes	☐ No	**If yes**: Which pets? _____

Name states and countries you have lived so far: _____

FAMILY HEALTH HISTORY (LIST HEALTH PROBLEMS OF FAMILY MEMBERS EXAMPLE: DIABETES, ASTHMA ETC)

Father		Grandparents
Mother		Other
Siblings		**☐ Do you have family members with heart attack/stroke before 60?**

HEALTH MAINTAINENCE HISTORY	
Last physical and blood test (mm/yyyy):	Date of last tetanus vaccine: _____ ☐ Not sure ☐ More than 10 years ago
Last mammogram (mm/yyyy):	Date of last pneumonia vaccine:_____ ☐ Not sure ☐ More than 5 years ago
Last bone density scan (mm/yyyy):	Date of last flu vaccine: _____ ☐ I do not want to take flu vaccine ☐ Not sure
Last colonoscopy (mm/yyyy):	Have you completed HPV vaccine 3 dose series? ☐ Not sure ☐ Yes
Last eye exam (mm/yyyy):	Other:
☐ I do not like to do preventive work up	

MENTAL HEALTH			
Any past history of mental health disorder or suicide attempt?		☐ Yes	☐ No
Have you ever been to a counselor?		☐ Yes	☐ No
Are you currently depressed? ☐ Yes ☐ No	If Yes: is it affecting your social life? ☐ Yes ☐ No	Do you have suicidal thoughts? ☐ Yes ☐ No	

WOMEN ONLY	
Date of last menstruation: _____ ☐ I do not remember	Pregnant or breastfeeding? ☐ Yes ☐ No
Heavy periods, irregularity, spotting, pain, or discharge? ☐ Yes ☐ No If yes: Details _____	
Last PAP test (mm/yyyy):	
Date of last pap and rectal exam? _____ ☐ Do you see gynecologist? If yes, who? _____	

MEN ONLY	
Do you get up to urinate during the night? ☐ Yes ☐ No	If yes, # of times_____ / night
Difficulty with erection or ejaculation? ☐ Yes ☐ No	
Last prostate or rectal exam (mm/yyyy)? _____	

CURRENT PROBLEMS FOR WHICH YOU WOULD LIKE FURTHER EVALUATION – WRITE DETAILS
☐ Back
☐ Dizziness
☐ Ear, nose, throat
☐ Feet, legs
☐ Heart
☐ Joints and muscles
☐ Lungs or breathing
☐ Stomach or digestion
☐ Urine
☐ Other:
Recent changes: ☐ Weight loss ☐ Weight gain ☐ Low Energy level ☐ Poor sleep ☐ Sleepy more ☐ Snoring
You may give details of your problems here in the space below: