HEALTH HISTORY INTAKE FORM

NAME: _____

DOB: _____

FRESH MEDICAL FAMILY CLINIC
Let Our Family Care For Yours

1. Are you allergic to any medications? *Please list below with the reaction*

1. _____ reaction: _____
2. _____ reaction: _____
3. _____ reaction: _____
4. _____ reaction: _____

2. Do you take any medication routinely or occasionally? *Please list below*

Medication	Dose	Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		

3. Have you had any hospitalizations or test not requiring surgery in the past? *Please list below*

1. _____
2. _____
3. _____

4. Have you had any surgeries in the past? *Please list below with approx. date below*

1. _____
2. _____
3. _____
4. _____

5. Have you ever had any problems with any of the below? *Please check all that apply and list the year and use the space below to explain*

☐Glaucoma	☐Aneurysm	☐Asthma	☐Thyroid disorder	☐Blood Clot
☐Seizures	☐Hypertension	☐COPD	☐Diabetes	☐Hepatitis
☐Stroke	☐Heart Attack	☐GERD	☐Mental Illness	☐Other
☐Migraine	☐Murmur	☐Ulcer	☐Cholesterol	

Name:_____DOB:_____

6. How many of the following do you consume daily and *how many*?

_____Cigarettes _____Beer _____Coffee _____Cigars

_____Tea _____Pipe _____Liquor _____Soft Drink

_____Electric Cigarette

7. Do you have any **FAMILY HISTORY** any of the following? *Please circle and list relative below*

YES/NO ARTHRITIS _____
YES/NO ASTHMA _____
YES/NO BLEEDING DISORDER _____
YES/NO CORONARY ARTERY DISEASE _____
YES/NO COPD _____
YES/NO DIABETES _____
YES/NO HEART ATTACK _____
YES/NO HEART DISEASE _____
YES/NO HIGH CHOLESTEROL _____
YES/NO HIGH BLOOD PRESSURE _____
YES/NO MENTAL ILLNESS _____
YES/NO OSTEOPOROSIS _____
YES/NO STOMACH ULCER _____
YES/NO STROKE _____
YES/NO CANCER* _____
YES/NO OTHER _____

*cancer, please list relative and type of cancer

8. Women Health History:

Last Period: _____ Number of Pregnancies: _____

Last PAP: _____ Number of Miscarriages: _____

Last Mammogram: _____ Number of living children: _____