# Health History Form

| **Patient Name:** | Type Name here | **Date:** | 01-01-2023 |
|---|---|---|---|
| **What is the reason for your visit today?** | | | Type here |
| **Please List all of your Medical Problems (current and old)** | | | Type here |
| Type here | | | |
| **Please List all of your Previous Surgeries** | Type here | | |
| Type here | | | |

| **Do any of these Medical Problems apply to you? Please Check box to the right of those that do.** | | | |
|---|---|---|---|
| Heart Disease | ☐ | Kidney Stones | ☐ |
| Diabetes | ☐ | Stomach Ulcers | ☐ |
| Depression | ☐ | Back Pain | ☐ |
| Diarrhea | ☐ | Heartburn | ☐ |
| Chest Pain | ☐ | Blood in your Urine | ☐ |
| Thyroid Disease | ☐ | Blood Transfusion | ☐ |
| Stroke | ☐ | Cancer: List type | ☐ |
| Constipation | ☐ | Asthma/Emphysema | ☐ |
| High Blood Pressure | ☐ | HIV or Hepatitis | ☐ |

- **Please list all the Medications you are presently taking.**

  Type here
  Type here

- **Are you Allergic to any Medications? (Please list)**

  Type here
  Type here

## Social History:

Do you smoke?_____ Yes : ☐ _____ No : ☐

If yes, how much? Type here : If you stopped, When? Type here

## Marital Status:

Single : ☐ / Married : ☐ / Separates : ☐ / Divorced : ☐ / Widowed : ☐