

Grace Medical Group of the Valley, Inc – Patient Health History Form

Name _____ Today's Date _____ / _____ / _____

Social History

Occupation _____ Education _____
 Religious Affiliation _____

Personal Health History

Hospitalizations		Surgeries	
Date	Reason	Date	Reason
/ /		/ /	
/ /		/ /	

Chronic Illnesses (Check all that Apply)

Hypertension
 Thyroid Disease
 Allergies
 Asthma
 Other _____
 Diabetes
 Depression
 Cancer
 Mental Illness
 Other _____

Medication (List all medication currently being taken, including over the counter and herbal medication)

Name	Strength	How Often

Drug Allergies

Medication	Type of Reaction	Medication	Type of Reaction

Immunization (Please write month and year of last Injection)

Pneumonia _____
 Hepatitis B _____
 Influenza _____
 Tetanus _____
 Tuberculosis Test _____
 Other _____

Do you use any of the following? (If so, how much and how often?)

Tobacco _____
 Alcohol _____
 Caffeine _____
 Street Drugs _____

Have you had any of the following risk factors for hepatitis or HIV (Check all that apply)

IV Drug Use
 Many Sexual Partners
 Blood Transfusion

Female Menstrual and Obstetric History

Age of Onset _____ Days of Flow _____ Length of Cycle _____ Regular Irregular Last PAP Smear _____
 # of Pregnancies _____ # of Live Births _____ # of Miscarriages _____ # of Abortions _____

Family Health History

<table border="0" style="width: 100%;"> <tr> <td style="width: 15%;"></td> <td style="width: 5%;">Yes</td> <td style="width: 5%;">No</td> <td style="width: 75%;">If Yes, specify who</td> </tr> <tr> <td>High Blood Pressure?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Heart Disease?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>High Cholesterol?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Cancer?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Diabetes?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> </table>		Yes	No	If Yes, specify who	High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____	<table border="0" style="width: 100%;"> <tr> <td style="width: 15%;"></td> <td style="width: 5%;">Yes</td> <td style="width: 5%;">No</td> <td style="width: 75%;">If Yes, specify who</td> </tr> <tr> <td>Mental Illness?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Kidney Disease?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Stroke?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Substance Abuse?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Other?</td> <td></td> <td></td> <td>_____</td> </tr> </table>		Yes	No	If Yes, specify who	Mental Illness?	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke?	<input type="checkbox"/>	<input type="checkbox"/>	_____	Substance Abuse?	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other?			_____
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Is your father still living? Yes No If No, what was the cause of death? _____ Age at Death? _____
 Is your mother still living? Yes No If No, what was the cause of death? _____ Age at Death? _____
 Number of Brothers? _____ Health problems with any? _____
 Number of Sisters? _____ Health problems with any? _____