MEDICAL HISTORY

Name:_____ Date of Birth:_____ Today's Date:_____

Person to Notify in Case of Emergency:_____

Name Address Phone Relationship

Are you allergic to any medications? ☐ Yes ☐ No

If yes, what are they?_____

What kind of reaction do you have?

Other Allergies? Food? Environmental?

Do you take any over the counter or prescription medications?

☐ Yes ☐ No Please list_____

_____

_____

Are you currently using any alternative Health Care Practices?

☐ Yes ☐ No Type_____

FAMILY MEDICAL HISTORY

Have any of your grandparents, parents, brother or sister had:

	Yes	No
High Blood Pressure/Stroke	☐	☐
Heart Attack	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
Epilepsy	☐	☐
Birth Defects	☐	☐
Tuberculosis	☐	☐
Alcoholism or Drug Abuse	☐	☐
Other Serious Illness	☐	☐

if yes, please describe_____

IMMUNIZATIONS:

When was your last:

Tetanus_____ MMR_____

Pneumonia Vac_____ Flu Shot_____

Hep B Vac_____ TB Test_____

Have you completed a childhood vac. series? ☐ Yes ☐ No

PERSONAL HEALTH HISTORY

Have you ever had:	Yes	No
Head, Eye, Ear, Nose or Throat Problems	☐	☐
Seasonal Allergies or Hayfever	☐	☐
Heart or Blood Pressure Problems, Anemia	☐	☐
Lung Disease	☐	☐
Stomach, Intestines, Liver Problems	☐	☐
Hemorrhoids	☐	☐
Bladder, Kidney Disease	☐	☐
Reproductive Organ Disease	☐	☐
Bone or Joint Problems	☐	☐
Skin Problems	☐	☐
Endocrine Disease (i.e. Thyroid)	☐	☐
Breast Problems	☐	☐
Neurological Problems	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Alcoholism or Drug Dependency	☐	☐
Sexual Abuse	☐	☐
Psychological / Emotional Problems (Depression, Anxiety, Insomnia)	☐	☐
Any Other Serious Illnesses	☐	☐

if yes, please describe_____

_____

List All Members of Your Household

Name Relationship Age

1._____

2._____

3._____

4._____

5._____

HOSPITALIZATIONS / SURGERIES

Type Date

_____

_____

_____

_____

MEDICAL HISTORY

HEALTH CARE EDUCATION

Which areas of health are you interested in learning more about?
Circle the subjects that interest you.

Exercise	Testicular Self-Exam
Cholesterol	Stress Management
Diabetes	Nutrition/Healthier Diet
Cancer	Household Safety
Pregnancy Planning	Breast Self-Exam
AIDS/HIV	Stopping Smoking
Weight Management	CPR
Heart Disease	Alcohol or Drug Abuse
High Blood Pressure	Injury Prevention
Parenting	Sexually Transmitted Diseases
Birth Control Methods	Domestic Violence Prevention
Alternative Health Care	

LIFESTYLE

What do you do for fun?_____

Diet: Do you eat all foods?_____ Vegetarian?_____
Vegan?_____

Education / Background_____

Occupation_____

Sexual Orientation_____

HABITS:

Do you	Yes	No	Amount	Kind
Exercise Regularly?	☐	☐	_____	_____
Have a Spiritual Practice	☐	☐	_____	_____
Drink Coffee/Tea/Sodas?	☐	☐	_____	_____
Smoke?	☐	☐	_____	_____
Drink Alcohol?	☐	☐	_____	_____
Use Recreational Drugs?	☐	☐	_____	_____

How do you describe your general health?
Excellent ☐ Good ☐ OK ☐ Poor ☐

What are your short term or long term health goals?

_____

Are you interested in making lifestyle changes to improve your health? ☐ Yes ☐ No

What prevents you from getting health care?

_____

How do you see our role as your health care provider?

_____

I certify that all information is correct to the best of my knowledge. **Consent for treatment:** I hereby authorize and consent to the procedures necessary for my diagnosis and treatment while a patient at the Petaluma Health Center.

Date:_____ Signature:_____
(Parent or Guardian, if minor)

Relationship to patient:_____