LABETTE HEALTH PHYSICIANS GROUP

HEALTH HISTORY

Patient Name: _____ Date: _____ Race: _____

Please check any problems listed below that you **have** or **have had**:

❍ ADHD	❍ Bronchitis	❍ Gout	❍ Insomnia	❍ Rheumatic Fever
❍ AIDS	❍ Cancer of Colon	❍ Headache/Migraine	❍ Kidney Disease	❍ Seizures
❍ Alcoholism	❍ Cancer of Lung	❍ Heart Attack	❍ Kidney Infections	❍ Stomach Ulcers
❍ Alzheimer's	❍ Cancer, Other	❍ Heart Failure	❍ Kidney Stones	❍ Stroke
❍ Anemia	❍ Cholesterol problems	❍ Heart Murmur	❍ Leukemia	❍ Substance Abuse
❍ Anxiety	❍ Colon Problems	❍ Heart Problems, Other	❍ Liver Disease	❍ Tingling/Numbness
❍ Arthritis	❍ Depression	❍ Heartburn/GERD/Indigestion	❍ Osteoporosis	❍ Thyroid Problems
❍ Asthma	❍ Diabetes	❍ Hemorrhoids	❍ Pacemaker	❍ Tuberculosis Disease
❍ Bleeding Disorder	❍ Dizziness/Vertigo	❍ Hepatitis A/B/C	❍ Parkinson's Disease	❍ UTI's
❍ Breast Cancer	❍ Emphysema	❍ Hypertension	❍ Prostate Problems	❍ Venereal Disease
❍ Breast Lumps	❍ Fractured Bones	❍ Hypoglycemia	❍ Rectal Bleeding	❍ Weight Change

OTHER: _____

DATE (approximately) of your last:

_____Pap Smear _____Mammogram _____Colonoscopy: _____Tetanus Shot

_____Flu Shot _____Pneumovax _____Hepatitis Shot _____ Lipids

I AM *ALLERGIC* TO THE FOLLOWING MEDICINES: _____

OR (INITIAL here) _____ I AM NOT ALLERGIC TO ANY MEDICATIONS THAT I AM AWARE OF.

Please list **ALL MEDICINES** you are currently taking (including prescription and non-prescription drugs, eye medications, patches)

Medicine	Dose	Frequency	Medicine	Dose	Frequency

Preferred Pharmacy: _____ City: _____

Have you ever used tobacco? ❑ No ❑ Yes How long? (yrs)_____ When did you quit? _____

What did you use? ❑ Cigarettes ❑ Chewing Tobacco ❑ Pipe ❑ Cigars

Do you drink alcoholic beverages? ❑ No ❑ Yes If Yes, what and how much? _____

Do you drink caffeinated beverages? ❑ No ❑ Yes Cups/glasses per day _____

Exercise regularly? ❑ No ❑ Yes If Yes, How and how often?

❑ Single ❑ Married ❑ Divorced ❑ Widowed _____

HEALTH HISTORY (CONTINUED)

Patient Name: _____ Date: _____

Female Patients: Number of pregnancies: _____ Number of live births: _____ Last menstrual period: _____

Male Patients: Date of last prostate exam: _____ PSA level: _____

Please list all surgeries and hospitalizations:

Date: _____ Reason: _____ Which Hospital? _____ Results: _____

Date: _____ Reason: _____ Which Hospital? _____ Results: _____

Date: _____ Reason: _____ Which Hospital? _____ Results: _____

Date: _____ Reason: _____ Which Hospital? _____ Results: _____

Date: _____ Reason: _____ Which Hospital? _____ Results: _____

Date: _____ Reason: _____ Which Hospital? _____ Results: _____

FAMILY HEALTH HISTORY

Please check if any blood relatives have had the following and give their relationship to you:

❍ Diabetes _____

❍ High Blood Pressure _____

❍ Heart Attack _____

❍ Stroke _____

❍ Epilepsy _____

❍ Arthritis _____

❍ Glaucoma _____

❍ Cancer Type of Cancer _____

❍ Cancer Type of Cancer _____

❍ Tuberculosis _____

❍ Emphysema _____

❍ Chronic Bronchitis _____

❍ Asthma/Allergies _____

❍ Stomach Ulcers _____

❍ Colon Problems _____

❍ Kidney Problems _____

❍ Bleeding Problems _____

❍ Thyroid Problems _____

❍ Sickle Cell Disease _____

❍ Mental Illness _____

❍ Any Other Chronic Illness or Disease _____

Present occupation: _____ Past occupation: _____

Signature: _____ Date: _____

Submit