



Initial Health Assessment

The following information is CONFIDENTIAL. It is used to evaluate your health profile and risk factors.

IDENTIFICATION DATA

DATE _____

Full Name _____ **Male** **Female**
First Middle Last Maiden (Circle One)

Address _____ **Marital Status**
Street Apt Single ~ Married ~ Divorced ~ Separated
City State Zip (Circle One)

Social Security Number _____ Date of Birth _____

Home Phone _____ Cell Phone _____ Work Phone/Ext _____
€ OK to leave message € OK to leave message € OK to leave message

E-mail address _____

Employer _____

What pharmacy do you use? _____
Name City Phone #

How did you hear about us? _____

Emergency Contact/Relation: _____ Phone: _____

PRESENT ILLNESSES:

Please list all illnesses or concerns that you would like to address with the doctor today:

1. _____ 3. _____

2. _____ 4. _____

CURRENT MEDICATIONS:

Please list ALL the medicines you are taking, including any over the counter medicines and vitamins.

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

PAST MEDICAL HISTORY:

List all medical problems you have had such as high blood pressure, heart disease, diabetes, asthma, etc.

1. _____

3. _____

2. _____

4. _____

DRUG ALLERGIES: List both the drug and your reaction upon taking it.

1. _____

3. _____

2. _____

4. _____

SURGICAL HISTORY: Please list all surgeries you have had and dates performed.

Operation	Year	Operation	Year
1.		4.	
2.		5.	
3.		6.	

FAMILY HISTORY: Please check or list any diseases that your relatives have now or have had.

	Age if Alive	Age at Death	Diabetes	High Blood Pressure	Heart Disease	Cancer	Other Disease
Mother							
Father							
Brother(s)							
Sister(s)							
Grandparents (Maternal)							
Grandparents (Paternal)							

PERSONAL HISTORY: Please list who lives with you.

Name, First & Last	Age	Relation to You	Name, First & Last	Age	Relation to You
1.			4.		
2.			5.		
3.			6.		

Have you ever smoked? Yes No How long? _____

Do you presently smoke? Yes No How much? _____

Do you use alcoholic beverages? Yes No How much? _____

Do you drink caffeinated beverages? Yes No How much? _____

Do you use seat belts? Yes No How often? _____

Do you use recreational drugs? Yes No Type? How often? _____

Do you have pets? Yes No If so, what type? _____

Is religion or spiritual belief important to you? Yes No If so, what religion? _____

Do you exercise at least 3 times/week? Yes No What type? _____

How would you describe your overall health? (circle one) Excellent Very Good Good Fair Poor

What is your race? American Indian/Alaskan Asian Hawaiian African American White Hispanic Other

What is your ethnicity? Hispanic Non-Hispanic Unknown Other _____

What is your preferred language? English Spanish Russian Indian Other _____

HEALTH SCREENING QUESTIONS FOR WOMEN

Do you examine your breast for lumps? Yes No

Have you had a pap smear? Yes No Date of Last Pap _____

Any history of an abnormal pap smear? Yes No When? _____

Have you had a mammogram? Yes No When/Results? _____

Please list dates of any pregnancy and outcomes _____

Have you ever been a victim of sexual or physical abuse? Yes No When? _____

HEALTH SCREENING QUESTIONS FOR MEN

Do you examine your testicles for lumps? Yes No

Have you had a prostate exam? Yes No When? _____

Have you had a PSA test? Yes No When/Results? _____

Have you had trouble achieving or maintaining an erection? Yes No

IMMUNIZATIONS/TESTS: Please give the date of your last immunization/test:

Tetanus _____ Flu shot _____ TB test _____ Cholesterol check _____

OVER AGE 50 ONLY: Pneumonia shot _____ Stool blood test _____ Colonoscopy _____

Signature _____

Date _____