

**CONFIDENTIAL HEALTH HISTORY**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Height \_\_\_\_\_ Date of last complete physical exam \_\_\_\_\_

Why are you here today to see the doctor? \_\_\_\_\_

**PAST MEDICAL CONDITIONS** - Check (√) conditions you have or have had in the past

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Thyroid Problem    |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Anorexia          | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Appendicitis      | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Migraine Headaches       | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Goiter               | <input type="checkbox"/> Miscarriage              |   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Multiple Sclerosis       |   |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Pacemaker                | Last Menstrual Period _____                 |
| <input type="checkbox"/> Breast Lump       | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Pneumonia                | Last Pap Smear _____                        |
| <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> Hernia               | <input type="checkbox"/> Prostrate Problem        | Last Mammogram _____                        |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Herpes               | <input type="checkbox"/> Psychiatric Care         | Are you pregnant? _____                     |
| <input type="checkbox"/> Cataracts         | <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Rheumatic Fever          |   |
| <input type="checkbox"/> Colitis           | <input type="checkbox"/> HIV Positive         | <input type="checkbox"/> Scarlet Fever            |   |

<b>MEDICATIONS</b>	<b>ALLERGIES</b>
List all medication you are presently taking	Medications/Substances

**FAMILY HISTORY**

Relation	Age	State of Health	Age at Death	Cause of Death	√ if your blood relatives had any of the following Disease	Relation to you
Father					Arthritis – Gout	
Mother					Asthma, Hay Fever	
Brother					Cancer	
					Chemical Dependency	
					Diabetes	
Sister					Heart Disease, Strokes	
					High Blood Pressure	
					Kidney Disease	
# of children					Tuberculosis	
					Other	

Please continue on other side

<b>SOCIAL HISTORY</b> – Check (√) which substances you use and describe how much you use them <input type="checkbox"/> Caffeine _____ <input type="checkbox"/> Tobacco # of packs per day _____ <input type="checkbox"/> Social Drug use _____ <input type="checkbox"/> Alcohol _____ of drinks per week/day	<b>OCCUPATIONAL HISTORY</b> <input type="checkbox"/> Have you ever been exposed to any hazardous substance? _____ <b><u>OCCUPATION:</u></b>
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**PAST SURGICAL HISTORY** – Please list any previous surgery and the date

Date	Type of surgery

Have you ever had problems in the following areas? **If yes, please explain**  
 (other than cold/flu symptoms)

<b>EYE, EAR, NOSE OR THROAT?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____	<b>SKIN, MUSCLES, JOINTS, OR BONES?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____
<b>GENITO –URINARY?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____	<b>GASTROINTESTINAL (ABDOMINAL AREA)</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____
<b>CARDIOVASCULAR?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____	<b>BLOOD or LYMPHATIC?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____

**HAVE YOU EVER HAD A BLOOD TRASFUSION?**  No  Yes

I certify that the above information is correct to the best of my knowledge. I will not hold Eastpointe Internists responsible for any omission/error I may have made in the completion of this form

\_\_\_\_\_  
 Patient signature Date

\_\_\_\_\_  
 Reviewed by Date