WHICH OF OUR PATIENTS REFERRED YOU TO US ? _____

HEALTH HISTORY **PRIMARY CARE PHYSICIAN** _____

NAME : _____ **DATE :** _____

D.O.B. : _____ **DATE OF LAST PHYSICAL EXAM :** _____

PHARMACY NAME : _____ **PHONE** _____

MEDICATIONS (list all medications you are taking below	****ALLERGIES LIST ALL MEDICATIONS & substances you are allergic to below**
	NONE ف

SOCIAL HISTORY		
substance		**how much**
Caffeine	**Y - N**	
Cigarettes	**Y - N**	
Alcohol	**Y - N**	
Tobacco	**Y - N**	

Have you ever had any of the following?

condition		**condition**	
Aids	**Y - N**	Herpes	**Y - N**
Alcoholism	**Y - N**	HIV +	**Y - N**
Anemia	**Y - N**	Hypertension	**Y- N**
Anorexia	**Y - N**	Kidney disease	**Y - N**
Appendicitis	**Y - N**	Liver disease	**Y - N**
Arthritis	**Y - N**	Measles	**Y - N**
Asthma	**Y - N**	Migraines	**Y - N**
Bronchitis	**Y - N**	Mononucleosis	**Y - N**
Bulimia	**Y - N**	Mumps	**Y - N**
Cancer	**Y - N**	Pacemaker	**Y - N**
Chemical dependency	**Y - N**	Pneumonia	**Y - N**
		Polio	**Y - N**
Chicken pox	**Y - N**	Psychiatric care	**Y - N**
Diabetes	**Y - N**	Rheumatic fever	**Y - N**
Emphysema	**Y - N**	Scarlet fever	**Y - N**
Epilepsy	**Y - N**	Stroke	**Y - N**
Glaucoma	**Y - N**	Tonsilitis	**Y - N**
Goiter	**Y - N**	Tuberculosis	**Y - N**
Gonorrhea	**Y - N**	Typhoid fever	**Y - N**
Gout	**Y - N**	Ulcers	**Y - N**
Heart disease	**Y - N**	Venereal disease	**Y - N**
Hepatitis	**Y - N**		
Hernia	**Y - N**		

PERSONAL HISTORY	
Y - N	***Abnormal pap smear***
Y - N	***Bleeding between periods***
Y - N	***Breast lump***
Y - N	***Extreme menstrual pain***
Y - N	***Hot flashes***
Y - N	***Nipple discharge***
Y - N	***Painful intercourse***
Y - N	***Vaginal discharge***

list any complications during child birth. _____

_____

_____

Date of last pap smear

_____

DATE OF LAST MAMMOGRAM

_____

Number of children _____

year of birth / sex / delivery type

/ /

/ /

/ /

/ /

/ /

PAST MEDICAL HISTORY :

FAMILY HISTORY : list any illness that runs in your family.

FILL IN HEALTH INFORMATION ABOUT YOUR FAMILY :

	AGE	**MEDICAL PROBLEMS**	**AGE AT AND CAUSE OF DEATH**	
FATHER				
MOTHER				
BROTHERS				
SISTERS				

X

PATIENT OR GUARDIAN SIGNATURE **DATE**

X

PHYSICIAN SIGNATURE **DATE**

WHICH OF OUR PATIENTS REFERRED YOU TO US ? _____

HEALTH HISTORY **PRIMARY CARE PHYSICIAN** _____

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substance		**how much**
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Cigarettes	**Y / N**	
Alcohol	**Y / N**	
Tobacco	**Y / N**	

PERSONAL HISTORY	
Y / N	***Erection difficulties***
Y / N	***Lump in testicles***
Y / N	***Penis discharge***
Y / N	

Date of last PSA. _____

Date of last prostate exam _____

Have you ever had any of the following?

condition		**condition**	
Aids	**Y / N**	Herpes	**Y / N**
Alcoholism	**Y / N**	HIV +	**Y / N**
Anemia	**Y / N**	Hypertension	**Y / N**
Anorexia	**Y / N**	Kidney disease	**Y / N**
Appendicitis	**Y / N**	Liver disease	**Y / N**
Arthritis	**Y / N**	Measles	**Y / N**
Asthma	**Y / N**	Migraines	**Y / N**
Bronchitis	**Y / N**	Mononucleosis	**Y / N**
Bulimia	**Y / N**	Mumps	**Y / N**
Cancer	**Y / N**	Pacemaker	**Y / N**
Chemical dependency	**Y / N**	Pneumonia	**Y / N**
		Polio	**Y / N**
Chicken pox	**Y / N**	Prostate problems	**Y / N**
Diabetes	**Y / N**	Psychiatric care	**Y / N**
Emphysema	**Y / N**	Rheumatic fever	**Y / N**
Epilepsy	**Y / N**	Scarlet fever	**Y / N**
Glaucoma	**Y / N**	Stroke	**Y / N**
Goiter	**Y / N**	Tonsilitis	**Y / N**
Gonorrhea	**Y / N**	Tuberculosis	**Y / N**
Gout	**Y / N**	Typhoid fever	**Y / N**
Heart disease	**Y / N**	Ulcers	**Y / N**
Hepatitis	**Y / N**	Venereal disease	**Y / N**
Hernia	**Y / N**		

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FAMILY HISTORY : list any illness that runs in your family.

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MOTHER					
BROTHERS					
SISTERS					

X

PATIENT OR GUARDIAN SIGNATURE **DATE**

X

PHYSICIAN SIGNATURE **DATE**