PERSONAL HEALTH HISTORY INFORMATION

Name:_____ Date:_____
Date of Birth:_____ Height:_____ Weight:_____

ALLERGIES:1._____ 2._____

MEDICATIONS: (Include doses)
1._____ 4._____
2._____ 5._____
3._____ 6._____

OPERATIONS: (Please list)
1._____ 3._____
2._____ 4._____

DO YOU HAVE OR EVER HAD?	YES	NO	How long – When Diagnosed – What?
1. Diabetes	___	___	_____
2. High Blood Pressure	___	___	_____
3. Heart Disease	___	___	_____
4. Pacemaker	___	___	_____
5. Other Heart Problems	___	___	_____
6. Kidney Disease	___	___	_____
7. Thyroid Disease	___	___	_____
8. Lung or Breathing Problems	___	___	_____
9. Cancer (incl. skin cancers)	___	___	_____
10.Bleeding Problems	___	___	_____
11.Transfusions	___	___	_____
12.HIV/AIDS	___	___	_____
13.Sickle Cell Anemia	___	___	_____
14.Trouble w/ anesthesia	___	___	_____
15.Any other medical problem	___	___	_____

DO YOU HAVE?	YES	NO		YES	NO
Headaches	___	___	Trouble urinating	___	___
Frequent coughs	___	___	Weight loss	___	___
Cough	___	___	Loss of appetite	___	___
Chest pain	___	___	Diarrhea or constipation	___	___
Shortness of breath	___	___	Arthritis	___	___

FAMILY HISTORY:

Has anyone in the family had?	YES	NO	Relationship – how old – age when diagnosed – type?
1. Cancer	___	___	_____
2. Diabetes	___	___	_____
3. Heart Disease	___	___	_____
4. Sickle Cell Anemia	___	___	_____
5. Bleeding Problems	___	___	_____
6. Problems with anesthesia	___	___	_____

SOCIAL HISTORY:
Do you smoke? ___YES___NO How much per day?___ Females: How many pregnancies?_____
Do you drink? ___YES___NO How much per day?___ How many deliveries? _____
Do you exercise?___YES___NO How much per day?___ When was your last mammogram?_____

How did you hear about Dr.Brooks?_____