

# HEALTH HISTORY

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

***Please circle appropriate answer and use best estimates on dates/years. If your answer is yes then please specify, if no then skip to next question. Please complete entire form(2 pages).***

Reason for today's visit: \_\_\_\_\_

Do you have any health problems such as diabetes, high cholesterol, high blood pressure etc?    Yes    No  
If yes, please specify:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had any major operation/surgery?    Yes    No  
If yes, please specify name and year of surgeries:

\_\_\_\_\_  
\_\_\_\_\_

Do you take any prescription or over-the-counter medication/supplement?    Yes    No  
If yes, please specify names of medication, dosage and how often you take it:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medication?    Yes    No  
If yes, please specify name and type of reaction: \_\_\_\_\_

Do any of your family members have health problem such as diabetes, heart disease, depression, high cholesterol, high blood pressure or cancer?    Yes    No  
If yes, please specify who has it and what illness:

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke or chew tobacco?    Yes    No    Never    Quit Date: \_\_\_\_\_

If you ever smoked or currently smoke, please specify how much per day: \_\_\_\_\_ Total number of years \_\_\_\_\_

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Do you use any recreational drugs? Yes No If yes, please specify: \_\_\_\_\_

Do you drink alcohol? Yes No If yes, how many drinks per week: \_\_\_\_\_

Do you have depression or mood disorder? Yes No If yes, please specify \_\_\_\_\_

Do you exercise regularly? Yes No If yes, how many hours per week: \_\_\_\_\_

Social history: Occupation: \_\_\_\_\_ Highest level of education: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Who lives with you at home? \_\_\_\_\_

Do you have any pets? Yes No If yes, please specify Dog Cat Other: \_\_\_\_\_

Are you sexually active? Yes No If yes, do you wish to be screened for sexually transmitted disease? Yes No

Immunization (specify date or year): Tetanus-Diphtheria \_\_\_\_\_ Pneumonia \_\_\_\_\_

Shingles \_\_\_\_\_ Other \_\_\_\_\_

Do you have a healthcare power of attorney or advance directive? Yes No

If yes, please specify and provide a copy if available: \_\_\_\_\_

*Above information is correct to the best of my knowledge and I release Parag B. Thakkar, MD of any liabilities as a result of false, incomplete or omitted information.*

Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(Patient or Guardian)