

# Personal Health History

Name: \_\_\_\_\_

Gender: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Place of birth: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

## Medical History:

<i>Previous operations</i>	Year	Hospital
_____	_____	_____
_____	_____	_____

<i>Previous injuries/medical conditions</i>	Year
_____	_____
_____	_____

<i>Mental illnesses</i>	Year diagnosed
_____	_____
_____	_____

## *Current prescription and non-prescription medications*

Medication	Dose	Duration on medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## *Drug allergies*

Medication	Reaction
_____	_____
_____	_____

## Preventative Health History

**Tobacco:** Ever used: \_\_\_\_\_ No. of cigarettes per day: \_\_\_\_\_ No. of cigars per day: \_\_\_\_\_

No. of years you smoked: \_\_\_\_\_ Have you ever quit? \_\_\_\_\_

**Alcohol:** No. of drinks per week: \_\_\_\_\_ Have you ever quit? \_\_\_\_\_ Have you abused alcohol? \_\_\_\_\_

**Drugs:** Have you ever used drugs? \_\_\_\_\_ When was your last use? \_\_\_\_\_ Which drugs? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Exercise:** Do you regularly exercise? \_\_\_\_\_ If yes, what type of exercise: \_\_\_\_\_

How often do you exercise per week? \_\_\_\_\_ Length of each session: \_\_\_\_\_

**Seat-belt use:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Diet:** No. of meals each day: \_\_\_\_\_ No. of glasses of water each day: \_\_\_\_\_ No. of snacks each day: \_\_\_\_\_

No. of servings of fruit per day: \_\_\_\_\_ No. of servings of vegetables per day: \_\_\_\_\_

No. of servings of meat per day: \_\_\_\_\_ No. of servings of dairy products per day: \_\_\_\_\_

**Smoke alarm in home:** Yes: \_\_\_\_\_ No: \_\_\_\_\_

**Gun:** Do you keep a gun in the home? \_\_\_\_\_ If yes, is it locked? \_\_\_\_\_ Is it loaded? \_\_\_\_\_

**Vaccinations:**

Vaccination	Year of last vaccination
Tetanus/diphtheria	_____
Pneumococcal vaccine	_____
Influenza vaccine	_____
Measles, mumps, rubella	_____
Polio	_____
Varicella (chicken pox)	_____
Hepatitis A	_____
Hepatitis B	_____

**Past and Current Physicians:**

Primary Physician/Specialty	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Health Insurance:**

Health insurance company: \_\_\_\_\_

Your identification no. \_\_\_\_\_

Phone number of insurance company: \_\_\_\_\_

Pre-admission phone number: \_\_\_\_\_