HEALTH HISTORY FORM*

NAME_____ DATE OF BIRTH_____ TODAY'S DATE_____

DO YOU HAVE AN ADVANCED DIRECTIVE? Yes No If yes, please provide a copy for your File

CURRENT MEDICATIONS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES & REACTIONS TO MEDICATIONS:

_____
_____

SURGERIES	**DATE**	**HOSPITALIZATIONS**	**DATE**

PLEASE **CIRCLE** ANY SYMPTOMS OR DISEASE YOU HAVE HAD:

MEASLES	KIDNEY DISEASE	GLAUCOMA	HEPATITIS	WHOOPING COUGH
MUMPS	NOSE BLEEDS	DIPTHERIA	POLIO	BLADDER INFECTION
HERNIA	CHICKEN POX	MONO	MENINGITIS	SCARLET FEVER
STROKE	VALLEY FEVER	CANCER	MALARIA	AIDS OR HIV
TB	THYROID PROBLEMS	PNEUMONIA	ARTHRITIS	BREAST LUMP
HIVES	CATARACTS	ASTHMA	BACK PAIN	VENEREAL DISEASE
PLEURISY	DIABETES	ANEMIA	ULCER	HIGH BLOOD PRESSURE
EMPHYSEMA	PACEMAKER	GOUT	HEART DISEASE	LIVER DISEASE
MULTIPLE SCLEROSIS		RHEUMATIC FEVER	ELEVATED CHOLESTEROL	

OVER

SOCIAL HABITS

SMOKING: NEVER or NO, QUIT _____ YEARS AGO
YES CURRENT SMOKER _____ CIGARETTES/ DAY _____
ALCOHOL: NONE or YES DRINKS / DAY _____
RECREATIONAL DRUG USE? NONE or YES HOW OFTEN _____
CAFFEINE: NONE or YES CUPS / DAY _____
EXERCISE: NO YES TYPE _____ TIMES / WEEK _____

FEMALE ONLY

DATE OF LAST MENSTRUAL PERIOD_____LAST MAMMOGRAM_____
OF PREGNANCIES AND CHILDREN _____LAST PAP _____

HAVE YOU EVER HAD?	**MOST RECENT DATE**
PNEUMOVAX	_____
FLU SHOT	_____
TETANUS TOXOID	_____
HEPATITIS SHOTS	_____
HEART CATHETERIZATION	_____
CAT SCAN OR MRI	_____
UPPER OR LOWER SCOPE OF BOWELS	_____

IMMEDIATE FAMILY HISTORY		MEDICAL PROBLEMS OR CAUSE OF DEATH
FATHER	PRESENT AGE OR AGE AT DEATH _____	_____
MOTHER	PRESENT AGE OR AGE AT DEATH_____	_____
BROTHERS (#)	_____ _____ _____	_____
	_____ _____ _____	_____
SISTERS (#)	_____ _____ _____	_____

*Submission of a form or information does not establish a physician-patient relationship.
*Physicians will not review this form before the prospective patient's first appointment.

Sierra Vista Internal Medicine, PLLC

DAVID J. KNAPP, M.D.