LAFAYETTE INTERNAL MEDICINE CLINIC

HEALTH HISTORY

(*Confidential*)

Name: _____ Today's Date: _____

Age: _____ Date of Birth: ___/___/___ Date of last physical exam: _____

What is your reason for visit? _____

CHRONIC CONDITIONS Check off conditions you have been diagnosed with in the past and/or are currently receiving treatment for:

□ AIDS	□ Chemical Dependency	□ High Cholesterol	□ Psychiatric Care
□ Alcoholism	□ Chicken Pox	□ HIV Positive	□ Rheumatic Fever
□ Anemia	□ Diabetes	□ Kidney Disease	□ Scarlet Fever
□ Anorexia	□ Emphysema	□ Liver Disease	□ STDs: _____
□ Appendicitis	□ Epilepsy	□ Measles	□ Stroke
□ Arthritis	□ Glaucoma	□ Migraine Headaches	□ Suicide Attempt
□ Asthma	□ Goiter	□ Miscarriage	□ Thyroid Problems
□ Bleeding Disorders	□ Gonorrhea	□ Mononucleosis	□ Tonsillitis
□ Breast Lump	□ Gout	□ Multiple Sclerosis	□ Tuberculosis
□ Bronchitis	□ Heart Disease	□ Mumps	□ Typhoid Fever
□ Bulimia	□ Hepatitis	□ Pacemaker	□ Ulcers
□ Cancer: _____	□ Hernia	□ Pneumonia	□ Vaginal Infections
_____	□ Herpes	□ Polio	□ Other: _____
□ Cataracts	□ High Blood Pressure	□ Prostate Problem	_____

PREVENTIVE CARE Please specify if and when you have had the following preventive care performed.

Screening Test	Date	Physician/Location	Specify if any abnormalities
Colonoscopy			
Bone Density			
Mammogram			
Pap smear			

SURGERIES/HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization or Type of Surgery

FAMILY HISTORY

Relation	State of Health (Living/Deceased)	Current Age	Age at Death	Cause of Death	List Medical Problems (Cancers, Heart Disease, etc)
Father					
Mother					
Brothers					
Sisters					

****Please continue on back of form****

PREGNANCY HISTORY

Year	Sex	Complication(s) if any

OCCUPATIONAL CONCERNS

Current Occupation: _____

Check if you're exposed to the following:

□ Stress □ Hazardous Substances □ Heavy Lifting Other: _____

HEALTH HABITS Check which substances you use and how often.

□ Caffeine: _____

□ Drugs: _____

□ Alcohol: _____

□Tobacco: □ Cigarettes □ Cigars □ Chewing Tobacco

□ How long have you smoked? _____

□ Packs per day: _____

□ Former smoker? How long_____ Quit date _____

Vaccination History: Please specify which, if any, of the following vaccines you have received.

Screening Test	Date
Flu shot	
Pneumonia shot(Pneumovax 23 or Prevnar 13)	
Tetanus or Tdap	
Shingles vaccine	
Other: MMR, Hepatitis A, B, Meningococcal	

LIST THE PHYSICIANS YOU ARE CURRENTLY SEEING AND THEIR SPECIALTY

_____

_____

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed by Date