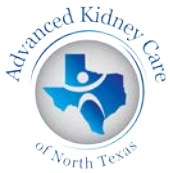

Health History

Please fill in the blank or circle the appropriate answer. Thank you.

Name:_____ Date of Birth:_____

Home Phone:_____ Cell Phone:_____

Other Doctors You See

_____ _____

_____ _____

_____ _____

Pharmacy Info:_____

Medications: Name, dose, and how often you take it

Drug Allergies:_____

Any history of the following:

High blood pressure:	Yes	No	Stroke/TIA:	Yes	No
Diabetes:	Yes	No	Kidney Stones:	Yes	No
Heart Disease:	Yes	No	CHF:	Yes	No

Other:_____

Do you use any: (Cirle what applies) Tylenol Motrin Ibuprofen Aleve Acetaminophen

Surgical History: List surgery and year

Family History: List any medical problems

Mother:_____ Deceased Age:_____

Father:_____Deceased Age:_____

Family History of the following?

Kidney Disease	Yes	No	Hypertension	Yes	No
Cancer	Yes	No	Coronary Artery Disease	Yes	No

Social History

Do you smoke? Yes (type)_____ Number of years used:_____ Quit (year)_____
No

Do you live: Alone With Others (who?)_____

Occupation:_____ Retired

Do you drink alcohol? No

Yes (type)_____Number of years used:_____ Quit (year)_____

Number of drinks per week_____

Illicit/Recreational drug use: Yes No

Check any problems you experience

□Fever/chills	□Persistent Cough	□Diarrhea	□Frequent Urination	□Straining to Urinate	□Bone or Joint Pain
□Night Sweats	□Wheezing	□Blood in Urine	□Up at night to urinate often	□Excess Urination	□Headaches
□Blurry Vision	□Nausea	□Kidney Stones	□Foamy Urine	□Leaky Bladder	□Dizziness or Vertigo
□Nosebleeds	□Vomiting	□Burning with Urination	□Weak Urine Stream	□Muscle pain or weakness	□Balance Problems
□Sinus Problems	□Irregular Heart Rate	□Swelling in hands or feet	□Shortness of breath	□Leg pain or cramps	□Constipation
□Chest Pain	□Abdominal Pain	□Confusion	□Excessive Thirst	□Chronic Fatigue	□Back Pain