

HEALTH HISTORY

Full Name

Birth Date (mm/dd/yyyy) First Middle Height Weight Last

Reason for today's visit

Medical history: None High blood pressure High cholesterol Diabetes GERD Stroke
Thyroid Overweight Seasonal Allergies Arthritis Asthma COPD Heart Disease
Anxiety Depression Atrial Fibrillation Kidney stone Cancer Varicose veins Migraine
Specify details and any other conditions not listed above:

Surgical History: None Appendix Gall Bladder Hernia C-section Thyroid Joint
Heart Pacemaker Carotid Fracture Stomach/Bowel Breast Lung Brain
Specify details and any other surgeries not listed above:

Tobacco use: None Former smoker Current every day smoker Current some day smoker
If any current or past tobacco use please specify: Example: Smoked 1 pack of cig/day for 10 years, quit in 98

Alcohol use: None Former Few times/year Few times/month Few times/week Daily
Number of alcoholic drinks per session, times daily week month year

Depression Screen: Feeling down, depressed or hopeless? Yes No

Recreational drug use: None Former use Current use Specify:

Exercise: None 2-3 times a week 4 or more times a week Specify

Education Completed: Grade school High school Some college Bachelors Masters or above
Specify

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Occupation: Employed Out of work Homemaker Student Retired Disabled

Specify

Marital Status: Single, never married Married Divorced Widowed Separated

Sexual Activity: Female partner Male partner None currently

Specify

Living situation: Alone Family Significant other Room-mate Other

Number of children: None Son/s Daughter/s

Who lives with you

Pets: None Dog Cat Bird Fish Other

Family History: None Diabetes Heart disease Cancer High blood pressure Stroke Other

Specify details:

Medications: No prescription medication No over-the-counter supplements

If taking any medication or supplements, please specify name, dosage and how often you take it:

Allergies to medications, Latex, food or bee sting: None Yes, as noted below

If any allergic to any medication, food or iodine please specify name and type of reaction:

Immunization: Please check box and specify most recent date (or estimated year).

Tetanus Date

Pneumonia Date

Shingles Date

Influenza(Flu) Date

Living will or Healthcare power of attorney: Yes No Specify:

Information provided in this form 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