HEALTH HISTORY

Full Name: First Middle Last

Birth Date: (MM/ DD/ YYYY) **Height:** Inches **Weight:** Pounds

Reason for today's visit:

Personal Medical history: ☐None ☐High blood pressure ☐High cholesterol ☐Diabetes ☐Seasonal Allergies ☐GERD ☐Thyriod ☐Stroke ☐Overweight ☐Arthritis ☐Asthma ☐COPD ☐Cancer ☐Anxiety ☐Depression ☐Atrial Fibrillation ☐Kidney stone ☐Heart Disease ☐Migraine ☐Varicose vein

Specify details and any other conditions not listed above:

Personal 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 ☐, Number of times ☐ a ☐day ☐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

Highest 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 childern: ☐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

Information provided in this form is correct to the best of my knowledge and I release Parag B. Thakkar, MD SC and staff of any liabilities as a result of false, incomplete or omitted information.

Signature: **Date:**