Patient Health History

(PEDIATRIC)

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____

Personal/Family Health History: Please check all areas that apply to the patient or their Mother or Father.

Indicate any history of:	Patient	Mother	Father	Indicate any history of:	Patient	Mother	Father
Depression/Anxiety/ADHD/ Drug use				Headaches/Migraines			
Anemia				Heart defect			
Asthma				Kidney (Renal) Problems/Kidney Stones			
Concussion/Head injury				Seizure/Epilepsy			
Diabetes				Other:			
Eczema							

List any past surgical and hospitalization history:

Date	Surgery/hospital stay

Please list below any medication (prescription and over the counter) and any vitamins the patient takes:

Name of medication	Dosage	How many times a day

Home Environment:

Are there any concerns for weight and/or school performance? Yes ☐ No ☐

Females Only:

Ever had a menstrual period? Yes ☐ No ☐ If yes, age of first menstrual period? _____

Completed by: _____ Date: _____

Patient Health History

(ADULT)

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____

Please list below any medication (prescription and over the counter) and any vitamins that you take:

Name of medication	Dosage	How many times a day

Personal/Family Health History: Please check all areas that apply to you or your Mother/Father.

Indicate any history of:	Yourself	Mother	Father	Indicate any history of:	Yourself	Mother	Father
Depression/Anxiety/ ADHD				Heart disease/Heart Attack/Heart Failure			
Alzheimer's				Hepatitis/Liver disease			
Anemia				High cholesterol			
Anxiety				High blood pressure (Hypertension)			
Arthritis				HIV			
Asthma/COPD				Osteoporosis			
Blood clots				Kidney (Renal) Problems/Kidney Stones			
Cancer				Seizures/Epilepsy			
Diabetes				Stroke			
Stomach Reflux/Heartburn				Thyroid disease			
Headaches/Migraines				Other:			

List past surgical and hospitalization history:

Date	Surgery/Operation/Hospital

Do you drink alcohol? Yes ☐ No ☐

If you did drink alcohol in the past, when did you quit? _____

Do you currently use any street drugs (including marijuana)? Yes ☐ No ☐

If yes, what kind? _____

Are there any concerns for weight? Yes ☐ No ☐

Completed by: _____ Date: _____