

Update Annual Health History

Please fill out the information found below to the best of your ability

Patient Name _____ **Birth date** _____

Past Medical History

Have you ever had the following: (circle "no" or "yes", leave blank if uncertain)

Hypertension	no	yes	Chest pain/Angina	no	yes	Back Trouble	no	yes	Any other disease	no	yes
MI	no	yes	Blood or Plasma	no	yes	High Blood Pressure	no	yes	(please list):		
Stroke/TIAs	no	yes	Transfusions	no	yes	Low Blood Pressure	no	yes	_____		
Claudication	no	yes	Migraine Headaches	no	yes	Mitral Valve Prolapse	no	yes	_____		
Scarlet Fever	no	yes	Heart palpitations	no	yes	AIDS or HIV+	no	yes	_____		
Congestive heart failure	no	yes	Diabetes	no	yes	Anxiety	no	yes	_____		
Congenital heart Disease	no	yes	Cancer	no	yes	Liver Disease	no	yes	_____		
Hyperlipidemia	no	yes	Shortness of breath	no	yes	Jehovah Witness	no	yes			
Rheumatic Fever	no	yes	Asthma	no	yes	Kidney Disease	no	yes			
Heart Disease	no	yes	Stroke	no	yes	Thyroid Disease	no	yes			
Arrhythmia	no	yes	Heart murmur	no	yes	Bleeding Tendency	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription)

Patient social history/Habits:

Marital Status: Single: ____ Married: ____ Separated: ____ Divorced: ____ Widowed: ____

Use of Alcohol: Never: ____ Rarely: ____ Moderate: ____ Daily: ____

Use of Tobacco: Never: ____ Previously, but quit: ____ Current packs/day: ____

Use of drugs: Never: ____ Dust: ____ Solvents: ____ Air-borne Particles: ____ Noise: ____

Excessive exposure at home or work to: Fumes: ____ Dust: ____ Solvents: ____ Air-borne Particles: ____ Noise: ____

Family Medical History:

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased (please explain the age and cause of death below)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

Family Member _____ Age _____ Cause of Death _____

Family Member _____ Age _____ Cause of Death _____

Family Member _____ Age _____ Cause of Death _____

Family Member _____ Age _____ Cause of Death _____

Family Member _____ Age _____ Cause of Death _____

Test Ordered

In the last year have you had any of the following tests ordered and when?

- ECG _____
- Stress ECG _____
- Holter _____
- Echo _____
- Chest X-ray _____
- Last Cholesterol _____
- Labs _____
- Pulmonary Function _____
- Cardiac Cath _____
- Open Heart Surgery _____
- Other _____
- Other _____

Signature of Patient, Parent or Guardian

Date