

# 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	Bleeding Tendency	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						

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

**Medications: (Include nonprescription)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Patient social history/Habits:**

Marital Status:      Single: \_\_\_\_      Married: \_\_\_\_      Separated: \_\_\_\_      Divorced: \_\_\_\_      Widowed: \_\_\_\_

Religious Preference:      Jehovah Witness: \_\_\_\_      Catholic: \_\_\_\_      Baptist: \_\_\_\_      Other: \_\_\_\_

Use of Alcohol:      Never: \_\_\_\_      Rarely: \_\_\_\_      Moderate: \_\_\_\_      Daily: \_\_\_\_

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

Use of drugs:      Never: \_\_\_\_      Previously, but quit: \_\_\_\_      Rarely: \_\_\_\_      Moderate: \_\_\_\_      Daily: \_\_\_\_

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

**Family Medical History:**

	<b>Father</b>	<b>Mother</b>	<b>Father's Parents</b>	<b>Mother's Parents</b>	<b>Siblings</b>	<b>Children</b>
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"/>
<b>Deceased</b> (please explain the age and cause of death below)	<input type="checkbox"/>	<input type="checkbox"/>	<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 \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date