Health History Form

Community Medical Clinic

* Required

1. **NAME** *

_____

2. **Please List all your Medications, including Name, Dose how often you take the medication**

_____

_____

_____

_____

_____

3. **Are you Allergic to any Medications** *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Name Allergies:

4. **Highest Education Level** *

Mark only one oval.

- ◯ High School
- ◯ Some College
- ◯ College Graduate
- ◯ Advanced Degree

5. **Marital Status** *

Mark only one oval.

- ◯ Married
- ◯ Single
- ◯ Separated
- ◯ Widowed
- ◯ Parent
- ◯ Significant Other

6. **Do You have any of the following Conditions**
Check all that apply.

- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Thyroid Problems
- [ ] Cancer
- [ ] Leukemia
- [ ] Psoriasis
- [ ] Chest Pain
- [ ] Heart Problems
- [ ] Heart Murmur
- [ ] Pneumonia
- [ ] Blood Clot in Lung
- [ ] Asthma
- [ ] COPD
- [ ] Emphysema
- [ ] Stroke
- [ ] Seizures
- [ ] Cataracs
- [ ] Kidney Disease
- [ ] Kidney Stones
- [ ] Crohn's Disease
- [ ] Colitis
- [ ] Anemia
- [ ] Jaundice
- [ ] Hepatitis
- [ ] Stomach Ulcer
- [ ] Other: _____

7. **Female History: AGE OF 1st PERIOD**

_____

8. **Female History: Number Pregnancies, Miscarriage and Abortions**

_____

9. **FEMALE : Are you Menopausal**
   Mark only one oval.

   - Yes
   - No

10. **FEMALE: Do you have regular periods**
    Mark only one oval.

    - Yes
    - No

11. **Do You Drink Alcohol, If yes, How much** *

    _____

12. **Do you Smoke Cigarettes or E-cigs** *
    Mark only one oval.

    - Yes
    - No

13. **Do you use smokeless Tobacco** *
    Mark only one oval.

    - Yes
    - No

14. **Does anyone in your family have any of the following**

Check all that apply.

- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Thyroid Problems
- [ ] Cancer
- [ ] Leukemia
- [ ] Psoriasis
- [ ] Chest Pain
- [ ] Heart Problems
- [ ] Heart Murmur
- [ ] Pneumonia
- [ ] Blood Clot in Lung
- [ ] Asthma
- [ ] COPD
- [ ] Emphysema
- [ ] Stroke
- [ ] Seizures
- [ ] Cataracs
- [ ] Kidney Disease
- [ ] Kidney Stones
- [ ] Crohn's Disease
- [ ] Colitis
- [ ] Anemia
- [ ] Jaundice
- [ ] Hepatitis
- [ ] Stomach Ulcer
- [ ] Other: _____