FIRSTCARE MEDICAL GROUP

HEALTH HISTORY FORM

First Name: _____ MI:_____ Last Name:_____ DOB:: _____

CURRENT MEDICATIONS, VITAMINS AND SUPPLEMENTS

	Name	Dose	Freq	Reason
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

PAST MEDICAL HISTORY

☐No Significant Past Medical Problems

☐Alcohol/drug abuse ☐Kidney disease

☐Arthritis ☐Liver disease

☐Asthma ☐Lung disease

☐Depression ☐Migraine

☐High blood pressure ☐Neurologic disease

☐Heart disease ☐Stroke

☐Cancer (type) _____

☐Other_____

ALLERGIES

Seasonal allergies? ☐No ☐Yes

Allergies to Medications or food? ☐No ☐Yes

	Medication Name /Food	reaction type
1.		
2.		
3.		
4.		
5.		
6.		

FAMILY HISTORY (specify relationship)

father, mother, brother, sister, children only

☐Cancer _____

☐Diabetes _____

☐High Blood Pressure _____

☐Heart Disease _____

☐Stroke _____

☐Mental Illness _____

☐Alcohol/drug abuse _____

☐Other _____

SOCIAL HISTORY

☐Single ☐ Married ☐ Widowed

Occupation _____

Have you ever smoked? ☐No ☐100+ cigarettes over your lifetime

Current tobacco user? ☐No ☐Cigarettes ☐Chew ☐Cigars

_____ per day

Do you drink alcohol? ☐No ☐Yes _____ drinks/week

Do you now use drugs? ☐No ☐Yes _____

PAST SURGERIES

		year
1.		
2.		
3.		
4.		
5.		
6.		
7.		