My Family Physicians

PATIENT HEALTH HISTORY FORM

Patient Name: _____**Birth date**: ____/____/____ **Today's Date**: ____/____/_____

Pharmacy Name: _____ Pharmacy Phone No: _____-_____-_____

Pharmacy Address: _____

PRIOR SURGERIES	CURRENT MEDICAL PROBLEMS

Please list ALL medications (prescription and non- prescription) that you take.

MEDICATION	DOSAGE	HISTORY (provide all that apply)	Date
		Last Physical	
		Last Mammogram	
		Last Colonoscopy	
		Last Pap Smear	

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, or Aspirin**? ☐ **NO** ☐ **YES**

Do you have any food, environmental, or drug allergies? ☐ **NO** ☐ **YES** (Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? ☐ **NO** and Never have ☐ **YES** (Please explain below) ☐ **FORMER SMOKER** **Quit date: _____**

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Do you drink alcohol? ☐ **NO** and Never have ☐ **Socially Only** ☐ **Daily** ☐ **Beer/ Wine** ☐ **Hard Liquor**

Do you **use any other street drugs**? ☐ **NO** and Never have ☐ **YES** Please specify_____ ☐ **FORMER USER**
Quit date: _____

Please describe any family health issue below:

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESSES/ REASON FOR DEATH
MOTHER			
FATHER			
SIBLING(S)			
OTHER HEREDITARY ILLNESS			

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: _____ Date: ____/_____/_____