ALLIANCE MEDICAL GROUP
HEALTH HISTORY FORM

NAME ________________________________ **OCCUPATION** ________________________________

Date of Birth _________________

PAST ILLNESSES (ROS)

Yes No
___ ___ Fatigue
___ ___ Weight change
___ ___ Vision problems
___ ___ Loss of hearing
___ ___ Loss of smell
___ ___ Bleeding gums
___ ___ Loss of taste
___ ___ Frequent sore throats
___ ___ Hoarseness
___ ___ Chest pain/palpitation
___ ___ Swollen legs/feet
___ ___ Shortness of breath
___ ___ Wheezing/Cough
___ ___ Blood in urine
___ ___ Difficult urination
___ ___ Heartburn
___ ___ Diarrhea
___ ___ Blood in stool
___ ___ Back trouble
___ ___ Stiff joints
___ ___ Arthritis
___ ___ Rash
___ ___ Lumps/nodules
___ ___ Numbness
___ ___ Dizziness
___ ___ Depression/Anxiety
___ ___ Diabetes
___ ___ High Blood Pressure
___ ___ Hay Fever
___ ___ Blood disorder
___ ___ Anemia
___ ___ Lymph node enlargement
___ ___ High Cholesterol
________Other_____________

IMMUNIZATIONS

	Year
___Rubella	________
___Measles	________
___Tetanus	________
___Hepatitis B	________
___Pneumovax	________
___Flu Vaccine	________
___Other	________

____

ALLERGIES

Please check any allergies that you have had and write down the reactions.

___Penicillin____
___Sulfa____
___Aspirin____
___Codeine____
___Bee Stings____
___Foods____
____
Other____

ALCOHOL USE: Yes_____ No_____ Quit_____
Amount____________ How often____________

TOBACCO USE: Yes_____ No_____ Quit_____
Number of cigarettes per day______________

SURGERIES

___Appendix ___Tonsils
___Gall Bladder ___Breast
___Uterus ___Fallopian Tubes
___D&C ___Ovaries
___Other____

HOSPITALIZATIONS

Please list dates and reason for each hospitalization

DATE	REASON
_____________	____
_____________	____
_____________	____

MEDICATIONS

Please list any medications you take, both prescription and over-the-counter. Give dosage and how often taken.

DRUG	DOSE	HOW OFTEN

FAMILY HISTORY

	Alive	Age	Health status or cause of death
Mother	Yes/No	_____	______________________________
Father	Yes/No	_____	______________________________
Brother/Sister	Yes/No	_____	______________________________
Brother/Sister	Yes/No	_____	______________________________

____ ________________________________
Patient/Legal Guardian Signature Date

____ ________________________________
Physician Signature Date