

HEALTH HISTORY

Name: _____ Date: _____

Date of Birth: _____ Soc.Security#: _____

Who referred you to Dr. Pollock: _____

Current Status

Primary reasons for this appointment

1. _____
2. _____
3. _____

Please list other doctors/health care practitioners involved in your care, past and present. Include the work-up performed, results, their recommendations and any treatment performed and its benefits.

<u>Doctor</u>	<u>Date</u>	<u>Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Injuries & Dates: *(even those that occurred in childhood)*

Birth Difficulties/Trauma: _____

Head Trauma/Concussion: _____

Dental Work (tooth extractions, braces): _____

Motor Vehicle Accidents: _____

Falls: _____

Sports Injuries: _____

Emotional Trauma: _____

Hospitalizations/Surgeries:

<u>Procedure</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____

Medications: Please list all medications (i.e., prescriptions, non-prescriptions, remedies, vitamins, supplements). Include dosage and number of times taken per day.

Allergies/Sensitivities (i.e. drugs, food, chemicals, environmental):

Past History (please include dates and treatment):

Nervous System (problems of brain or nerves): _____

Visual System (problems with eyes or vision): _____

Ears (hearing, dizziness, infections): _____

Respiratory System (sinus, mouth, throat, lungs): _____

Heart (blood pressure): _____

Abdomen (stomach, liver, intestines, hernia): _____

Urinary System (kidney, bladder): _____

Musculoskeletal System (muscles, ligaments, bones, spine): _____

Skin (rashes, dryness, lesions, moles): _____

Reproductive System – Female:

Gynecologist: _____

Pregnancies – Number: _____ Term: _____ Premature: _____ Living: _____

Labor/Delivery: _____

Menstrual History: _____

Last Annual Physical/PAP: _____

Last Bone Density Test: _____

Last Mammogram: _____

Regular Self-Breast Exams: Y or N

Reproductive System – Male

Prostate, Penis, Infections: _____

PSA: Y or N Date: _____ Results: _____

Illnesses: (with dates)

Cancer _____ Eating Disorders: _____

HIV/Aids _____ Depression: _____

Thyroid Disease: _____ Childhood Disease: _____

Diabetes Mellitus: _____ Other: _____

STD's _____

Immunizations: (check those you have received, with most recent date)

Polio _____

DPT _____

Pneumonia _____

Tetanus _____

Flu _____

Hepatitis A _____

Chickenpox _____

Hepatitis B _____

MMR _____

Meningitis _____

HPV _____

Other _____

Lifestyle:

	<i>Amount</i>	<i>Frequency</i>	<i># Years</i>	<i>When Quit</i>
Smoking:	_____	_____	_____	_____
Drinking:	_____	_____	_____	_____
Drugs (name):	_____	_____	_____	_____
Caffeine:	_____	_____	_____	_____

Hobbies:

Physical Activity (type/frequency):

Eating Habits/Diets: (list foods)

Breakfast _____

Lunch _____

Dinner _____

Safety Measures:

Air Bag	Y	N	Always	Ski Helmets	Y	N	Always
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Seat Belts	Y	N	Always	Bike Helmets	Y	N	Always
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Radon Testing	Y	N	Always	Sunscreen	Y	N	Always
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Smoke Detectors	Y	N	Always	Sunglasses	Y	N	Always
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Emergency Exit Plan for Home Y or N

Home Environment:

Type of Lodging: _____

Exposures/Hazards (asbestos, mold, dust, etc.): _____

Other People/Relationships: _____

Pets: _____

Quality of Life: _____

Transfusions: No ___ Yes ___ Date: _____

Military Experience: _____

Foreign Travel: _____

Occupation: (responsibilities, environment, ergonomics, satisfaction):

Employer's Name & Address: _____

Spouse's Name: _____ Date of Birth: _____ Occupation: _____

Family Medical History: (please give the following information about your immediate family)

Relationship	Living/Age	Health Status	If Deceased/Age/Cause
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Family History/Relatives: (self or family)

Allergies/Sensitivities to environment and/or other substances: _____

Nervous System Disorders: (stroke, Alzheimer's, numbness) _____

Heart Disorders: _____

High Blood Pressure: _____

Digestive Problems: (food intolerance) _____

Cancer: _____

Respiratory Disease: (TB, chronic lung disease) _____

Emotional Problems: _____

Fibromyalgia: _____

Chronic Fatigue Syndrome: _____

Substance Abuse: _____

Any additional information you would like to add or questions you have: _____

For Physician Use Only:

Review/Changes in Medical History

Date/Initial _____