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.

Doctor	Date	Treatment

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*:*

Procedure	Date

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:

	Amount	*Frequency*	*# Years*	*When Quit*
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
Seat Belts	Y	N Always	Bike Helmets	Y	N Always
Radon Testing	Y	N Always	Sunscreen	Y	N Always
Smoke Detectors	Y	N Always	Sunglasses	Y	N Always

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 _____ _____ _____