



PERSONAL HEALTH SURVEY

Name _____ Birth Date _____ Age _____ M ___ F ___ Date: _____

Past Medical History: Check if applicable;

Asthma		Heart Attack	
Ulcer		High Cholesterol	
Diabetes		Kidney Problem	
High Blood Pressure		Hormone Problem	
Thyroid Problem		Cancer – Indicate Site?	
Liver Problem		Abnormal Heart Rate	
Blood Problem		Other	

Medications: (include birth control, vitamins and herbal preparations):

Do you have any allergies? If so, please indicate (include medications, insect stings, environmental factors ,food):

Operations: Have you had any surgery? YES NO

List: _____ Appendectomy _____ Hysterectomy (if so, reason _____) _____ Gall Bladder _____ Bypass
 _____ Joint Replacement _____ Ovaries Removed _____ Other (Explain _____)

Do you smoke? ___ NO ___ YES - **Do you consume alcohol?** ___ NO ___ YES: _____ drinks/week

Recreational Drug Use? ___ NO ___ YES **Exercise:** ___ NO ___ YES How Often? _____

Do You Wear Seatbelts? _____ **Are you Employed?** ___ NO ___ YES If so, ___ Full Time ___ Part Time ___

Employer, if any _____ **Marital Status:** Married Single Divorced Separated/Widowed

Recent Hospitalizations? _____ **Serious Injuries?** _____

Family History:

Condition	Mother	Father	Sibling
Heart Disease			
Respiratory Disease			
High Blood Pressure			
Diabetes			
Blood Problems			
Asthma			
Stroke			
Mental Illness			
Other			

GYN History: Number of Pregnancies: _____ Number of Children _____ Birth Control Method _____

Last Pap Test: _____ History of Abnormal Pap ___ No ___ YES Last Mammogram _____ Self-Breast Exam: Y N

Health Care Maintenance: Last Physical Exam: _____ Last Tetanus: _____ Hepatitis B _____

Pneumovax _____ Last Blood Work _____ Last Colonoscopy _____ Last DEXA Scan _____

Last PSA _____