
# Centralized Scheduling Health History Form

**Name:** _____ **Gender:** _____ **Age:** _____ **Date of Birth:** ___/___/___

**Previous Clinician(s):** _____

**Other Medical Provider(s):** _____

**Current Medical Problems:** _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

**Current Prescription Medications** (please attach additional page(s) if more room is needed):

| Name | Dosage | Number of times taken each day | Reason/Diagnosis | Refill Due |
|---|---|---|---|---|
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**Over the counter medications:** _____

**Medication Allergies:** _____

**Other Allergies:** _____

**Previous Hospital Admissions:**_____

_____

_____

**Previous Surgeries:**_____

_____

_____

**Family Medical History:**

| | Cancer* | Heart Attack | Stroke | Diabetes | High B/P | High Cholesterol | Kidney Disease | Mental Health |
|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | |
| Father | | | | | | | | |
| Siblings | | | | | | | | |
| Children | | | | | | | | |

*What type(s) of cancer: _____

**Health Screenings** (Please indicate date of last/most recent screenings where applicable and any outcomes):

| **Screening** | **Date** | **Comments/Outcomes** |
|---|---|---|
| Physical | | |
| Dental | | |
| Mammogram | | |
| Colonoscopy | | |
| Pap smear | | |
| Prostate Exam | | |
| Eye Exam | | |
| Vaccinations | | |

**Social History:**

**Marital Status: _____** **Members of household** (name, age, relationship to patient): **_____**

**_____**

**Please indicate never, former, or current for the following questions: Alcohol use: _____ Caffeine use: _____**

**Tobacco use** (and how many per day): **_____** **Drug use** (and which drug(s)):**_____**

| **Do you have any of the following?** | **Yes** | **No** | **Comments** |
|---|---|---|---|
| Weight Problems | | | |
| Vision Problems | | | |
| Hearing Problems | | | |
| Breathing problems | | | |
| Heart Problems | | | |
| Stomach problems | | | |
| Kidney or Urinary Problems | | | |
| Intestinal Problems | | | |
| Sexual Problems | | | |
| Muscle/joint Problems | | | |
| Skin Problems | | | |
| Nerve problems | | | |
| Memory Problems | | | |
| Walking Problems | | | |

Have you fallen in the past year? _____ # of Times: _____ Describe Any Injury:_____

_____ Do you drive? _____

In general do you feel healthy? _____ If no, why not? _____

Do you have any concerns about your health today? Please provide details: _____

_____

_____

**Thank you for taking time to fill out this form. It helps us to provide the best care possible.**