H&W Clinic

General History

Name:_____ DOB:_____ Date:_____

Drug Allergies:_____

Current Meds:_____

Hospitalization/Surgeries:_____

Women Only:

Pregnant Yes No
Planning Pregnancy Yes No
Hysterectomy Yes No
Age at first Menses_____Menopause_____
Age at first intercourse_____

Social History:

Occupation:_____ Education:_____Hobbies:_____Marital Status_____

Habits & Risk Factors:

___Smoke:Packs Daily_____
How Long_____
When Stopped_____

H/O Physical or Sexual Abuse_____
Work Related Toxin Exposure_____
Living Conditions_____

Immunizations:

_____TD when_____
_____PPD when_____
_____Hep B when_____

PAST MEDICAL HISTORY

_____ Allergies
_____ Abnormal sores
_____ Abnormal weight loss
_____ AIDS
_____ Anemia
_____ Arthritis
_____ Asthma
_____ Back Pain
_____ Bowel Irregularity
_____ Bronchitis
_____ Cancer
_____ Chest Pain
_____ Chicken Pox
_____ Chronic Rashes
_____ Depression
_____ Diabetes
_____ Dizziness/Fainting
_____ Emphysema
_____ Frequent Infections
_____ Gall Bladder Disease
_____ GI Disorder
_____ Gout
_____ Hair Loss
_____ Headache
_____ Hearing Problem
_____ Heart Disease
_____ Heart Murmur
_____ Heart Palpitations
_____ Hemorrhoids
_____ Hepatitis
_____ Hernia
_____ High Blood Pressure
_____ High Cholesterol
_____ HIV Positive
_____ Injuries
_____ Memory Loss
_____ Mumps
_____ Muscle Weakness
_____ Nervousness
_____ Peripheral Vascular Disease
_____ Pneumonia
_____ Prostate Disease
_____ Rheumatic Fever
_____ Ringing in the ear
_____ Seizure/Epilpesy
_____ Sexual/Menstrual Dysfunction
_____ Shortness of Breath
_____ Skin Problem
_____ Stroke
_____ TB
_____ Thyroid Disorder
_____ Ulcer
_____ Venereal Disease
_____ Vision Problem

___Other Tobacco:_____
___Alcohol:Type/Amount_____
___Coffee:cups daily_____
___Other Caffeine:_____
___Sleep Pattern:_____
___Other Tobacco:_____
___Other Drugs:_____
Number of sexual Partners_____

Exposure History:

___Asbestos
___Benzene
___Ethylene Oxide
___Excessive Noise
___Formaldehyde
___Lead
___Mercury
___PCB'S
___Pesticides/Herbicides
___Silica
___Vinyl Chloride

_____
Patient Signature

_____
Doctor Signature

	Mother	Father	Grandparents	Siblings	Children
Heart Disease					
High Blood Pressure					
Diabetes					
Cancer					
Glucoma					
Stroke					
Epilepsy					
Blood Disorder					
Thyroid Disorder					
Mental Illness					