HEALTH HISTORY FORM

Name: Date of Birth:

Medical History

Question	Response	Date first noted (approx)	Comments
Allergies	☐ Yes ☐ No		
COPD/chronic bronchitis	☐ Yes ☐ No		
Lung cancer	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No		
Dementia	☐ Yes ☐ No		
Migraines	☐ Yes ☐ No		
Anxiety	☐ Yes ☐ No		
Depression	☐ Yes ☐ No		
Myocardial infarction	☐ Yes ☐ No		
Arthritis	☐ Yes ☐ No		
Diabetes mellitus	☐ Yes ☐ No		
Nerve/muscle disease	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No		
Eye Disease	☐ Yes ☐ No		
Brittle bones	☐ Yes ☐ No		
Autoimmune Disease	☐ Yes ☐ No		
Acid reflux	☐ Yes ☐ No		
Prostate cancer	☐ Yes ☐ No		
Bipolar disorder	☐ Yes ☐ No		
Glaucoma	☐ Yes ☐ No		
Seizures	☐ Yes ☐ No		
Breast cancer	☐ Yes ☐ No		
Gout	☐ Yes ☐ No		
Skin cancer	☐ Yes ☐ No		

JOHN MUIR HEALTH
John Muir Physician Network

HEALTH HISTORY FORM

Name: Date of Birth:

Medical History (continued)

Question	Response	Date first noted (approx)	Comments
Cancer	☐ Yes ☐ No		
Heart Murmur	☐ Yes ☐ No		
Sleep apnea	☐ Yes ☐ No		
Cardiovascular other	☐ Yes ☐ No		
Hyperlipidemia	☐ Yes ☐ No		
Stroke/CVA	☐ Yes ☐ No		
Celiac disease	☐ Yes ☐ No		
High blood pressure	☐ Yes ☐ No		
Substance abuse	☐ Yes ☐ No		
Congestive heart failure	☐ Yes ☐ No		
Kidney disease	☐ Yes ☐ No		
Thyroid disease	☐ Yes ☐ No		
Bleeding problem	☐ Yes ☐ No		
Kidney stones	☐ Yes ☐ No		
Tremors	☐ Yes ☐ No		
Colon cancer	☐ Yes ☐ No		
Leukemia	☐ Yes ☐ No		
Ulcers	☐ Yes ☐ No		

Surgical History

Question	Response	Occurrence date (approx)	Comments
Appendectomy	☐ Yes ☐ No		
Dental surgery	☐ Yes ☐ No		
Prostate surgery	☐ Yes ☐ No		
Vasectomy	☐ Yes ☐ No		

JOHN MUIR HEALTH
John Muir Physician Network

HEALTH HISTORY FORM

Name: Date of Birth:

Surgical History (continued)

Question	Response	Occurrence date (approx)	Comments
Brain surgery	☐ Yes ☐ No		
Eye surgery	☐ Yes ☐ No		
Small intestine surgery	☐ Yes ☐ No		
Vein surgery	☐ Yes ☐ No		
Breast surgery	☐ Yes ☐ No		
Foot surgery	☐ Yes ☐ No		
Spine surgery	☐ Yes ☐ No		
Heart bypass	☐ Yes ☐ No		
Fracture surgery	☐ Yes ☐ No		
Thyroid surgery	☐ Yes ☐ No		
Gall bladder removal	☐ Yes ☐ No		
Hernia repair	☐ Yes ☐ No		
Tonsillectomy	☐ Yes ☐ No		
Colon/large intestine surgery	☐ Yes ☐ No		
Hysterectomy	☐ Yes ☐ No		
Tubes tied	☐ Yes ☐ No		
Plastic surgery	☐ Yes ☐ No		
Joint replacement	☐ Yes ☐ No		
Ear tubes	☐ Yes ☐ No		
C-Section	☐ Yes ☐ No		
Ovary removal	☐ Yes ☐ No		
Heart valve replacement	☐ Yes ☐ No		

HEALTH HISTORY FORM

Name: Date of Birth:

Family History

Item	Family Member (i.e. mother, father)	Name	Comments
Allergies			
Anxiety/Depression			
Arthritis			
Asthma			
Breast cancer			
Clotting disorder			
Colon cancer			
COPD			
Crohn's/Ulcerative Colitis			
Dementia			
Diabetes			
Glaucoma			
Heart disease			
Hyperlipidemia			
Hypertension			
Kidney disease			
Learning disabilities			
Lung cancer			
Macular degeneration			
Mental retardation			
Migraines			
Osteoporosis			
Ovarian cancer			
Prostate cancer			

JOHN MUIR HEALTH
John Muir Physician Network

HEALTH HISTORY FORM

Name: Date of Birth:

Family History (continued)

Item	Family Member (i.e. mother, father)	Name	Comments
Skin cancer			
Stroke			
Thyroid disease			

Social History

Alcohol Use ☐ Yes ☐ No

Drinks/Week
☐ Glasses of wine
☐ Cans of beer
☐ Shots of liquor
☐ Drinks containing 0.5 oz of alcohol

Comments

Tobacco Use ☐ Current Everyday Smoker ☐ Current Some Day Smoker ☐ Never ☐ Former Smoker ☐ Passive

Packs/Day
☐ 0 ☐ 0.25 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 3
☐ Other (specify here)

Years
☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35
☐ 40 ☐ Other (specify here)

Quit Date

Comments on your history with tobacco:

Drug Use ☐ Yes ☐ No