PT#_____

Patient Name _____ DOB _____

HEALTH HISTORY

Place of birth_____
Highest level in school_____
Occupation_____
Marital Status_____
Allergies & type of reaction_____
_____
_____

Smoking & Amt per day_____
if quit, when_____
Alcohol (type & amt per week)_____
Street drugs (type & amt)_____
Hobbies _____
Exercise _____

Past Medical History

List all serious illness _____
_____
_____
_____

Past Surgical History –List surgery, reason, and year

1._____
2._____
3._____
4._____
5._____

Family Health History

Are you adopted?_____

	Alive?	Yr of birth	Yr of death	Significant medical problems
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sibling 1	_____	_____	_____	_____
Sibling 2	_____	_____	_____	_____
Sibling 3	_____	_____	_____	_____
Other	_____	_____	_____	_____

Additional Notes

_____

_____