Marshall Family Practice
Marshall, MO

Patient Health History

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY!

Name: _____ Birth Date: _____

Age: _____ Sex: _____ Marital Status: _____ Occupation: _____

PAST HEALTH HISTORY

Please list all previous hospitalizations, surgeries, injuries, and blood transfusions. Include dates, hospitals, and physicians.

_____

_____

_____

_____

_____

CURRENT HEALTH STATUS

ALLERGIES: Include any medications, foods, or other things to which you are allergic.

_____

_____

CURRENT MEDICATIONS: Please list all medications which you are currently taking (be sure to include over-the-counter, contraceptives, and medications taken only occasionally).

Name of Medication	Strength	How Often	Date Began	Date Last Taken

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

High Blood Pressure	Y	N	Bleeding Disorder	Y	N
Heart Disease	Y	N	Thyroid Disorder	Y	N
Stroke	Y	N	Liver Disease	Y	N
Diabetes	Y	N	Epilepsy/Seizures	Y	N
Cancer	Y	N	Asthma	Y	N
Lung Disease	Y	N	Kidney Disease	Y	N
Ulcers	Y	N	Alcohol/Drug Addiction	Y	N
Arthritis	Y	N	Anxiety	Y	N
Headaches	Y	N	Depression	Y	N
Anemia (low iron)	Y	N	H.I.V.	Y	N

Please list other illnesses which you think would be important to your care.

_____

_____

_____

LIFE HABITS:

1 Do you use, or have you ever used, tobacco in any form? Y N
If yes: Age started_____ Age quit_____ Type and amount_____

2 How much coffee, tea, and/or soda do you drink in a day?_____

3 How much alcohol do you drink?
Daily_____ Weekly_____ Less than 3 per month_____ Never_____

4 How many hours of sleep do you get within a 24-hour period?_____
Do you generally feel rested? Y N

5 What types of exercise do you practice?
Running_____ Aerobics_____ Walking_____ None_____ Other_____

6 What activities do you do for fun?_____

7 Former schooling:_____

8 Occupation:_____

FAMILY HEALTH HISTORY:

To your knowledge, do any of your immediate family members have the following? If yes, who?

High Blood Pressure	_____	Bleeding Disorder	_____
Heart Disease	_____	Thyroid Disorder	_____
Stroke	_____	Liver Disease	_____
Diabetes	_____	Epilepsy/Seizures	_____
Cancer	_____	Asthma	_____
Lung Disease	_____	Kidney Disease	_____
Ulcers	_____	Alcohol/Drug Addiction	_____
Arthritis	_____	Anxiety	_____
Headaches	_____	Depression	_____
Anemia (low iron)	_____	H.I.V.	_____

_____ _____
PATIENT'S SIGNATURE DATE

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Pediatric Patient Health History

Name of Child: _____
LAST FIRST MIDDLE

Age: _____ Date of Birth: _____ Race: _____ Sex: _____

Father's Name: _____ Mother's Name: _____

Age: _____ Education: _____ Age: _____ Education: _____

Who does the child live with? _____ Who is legally responsible for the child? _____

Siblings: List name(s), age(s) and health problems: Others in the home?

_____

_____

_____

_____

Prenatal & Birth History

How many times have you been pregnant? _____ How many live births? _____

During this child's pregnancy did you use: vitamins____ alcohol____ tobacco____ drugs____

What type of delivery? vaginal____ C-Section____ Any complications? _____

Was this child premature? _____ Birth weight _____ Length _____

Childhood Health Problems

Any known allergies: _____

Childhood illnesses: _____

Injuries: _____

Surgeries: _____

Does anyone in the house smoke? Yes No If yes, whom: _____

Are the child's immunizations up to date? _____ Please provide a copy of this record.

Other health concerns: _____

_____

_____

Family History

Please check all that apply.

☐ Allergies ☐ Diabetes ☐ Cystic Fibrosis ☐ Heart Disease ☐ Cancer ☐ Drug Abuse
☐ Hypertension ☐ Birth Defects ☐ TB ☐ Sickle Cell ☐ Asthma ☐ Seizures

_____ _____
Signature of Person Completing Form Date