OGDENCLINIC

HEALTH HISTORY

For office use only	
Height	
Weight	
BP	/

Patient Name:	Date of Birth: / /
Insurance:	

What is the reason for your visit today?_____

MEDICATIONS AND ALLERGIES		
Please list any medications you are **currently taking**:		
Do you have any **allergies** to medications? If so, please list	No Yes	

MEDICAL HISTORY		
Are you currently being treated for **any medical conditions**? If so, please list:	No Yes	
Have you had any **past health problems**? If yes, please list:	No Yes	

SURGICAL HX

HAVE YOU HAD ANY **SURGERIES**? **NO** **YES**

DATE	SURGERY

HOSPITALIZATION HX

HAVE YOU BEEN **HOSPITALIZED** FOR ILLNESSES OTHER THAN SURGERIES OR CHILDBIRTH?

NO **YES**

DATE	REASON

FAMILY HISTORY

Do any of your **family members** have any of the following medical conditions?

	DIABETES	HIGH BLOOD PRESSURE	HEART DISEASE	STROKE	COLON CANCER	BREAST CANCER	PROSTATE CANCER	OTHER
Father								
Mother								
Brother								
Sister								
Son								
Daughter								

PLEASE COMPLETE BOTH SIDES

SOCIAL HISTORY					
Do you **smoke**?			No	Yes	Past
If yes, how many cigarettes daily?					
Do you use **alcohol**?			No	Yes	Past
If yes, how many drinks per week?					
Do you use **street drugs**?			No	Yes	Past
Marital Status:	Married	Single	Divorced	Engaged	Widowed

HEALTH MAINTENANCE	DATE	LOCATION
When and where was your last COLONOSCOPY?	/ /	
When and where was your last CHOLESTEROL TEST?	/ /	
When and where was your last MAMMO for women?	/ /	
When and where was your last PAP for women?	/ /	

FOR OFFICE USE ONLY

IMMUNIZATION	DATE	GIVEN AT:

PLEASE COMPLETE BOTH SIDES