Revised 01/08/2010

Date ________________________ Age ____ Date of birth ____________________

Check if you have or have ever had any of the following:

- ❑ Abnormal PAP
- ❑ Abuse
- ❑ AIDS
- ❑ Alcoholism/Drug addiction
- ❑ Allergies
- ❑ Anorexia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorder
- ❑ Blood clots to legs or lungs
- ❑ Blood transfusion
- ❑ Cancer What kind ________________
- ❑ Chicken pox
- ❑ Depression
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ HIV positive
- ❑ Liver disease
- ❑ Migraines
- ❑ Sexually transmitted disease
- ❑ Skin disorders
- ❑ Stroke
- ❑ Suicide attempts
- ❑ Thyroid problem
- ❑ TB
- ❑ Ulcer
- ❑ ____________________

Other serious illnesses or injuries ____

____

____

____

____

____

ALLERGIES/REACTIONS ____

____

MEDICATIONS ____

____

____

____

____

SIGNATURE ____ **DATE** ____________________

Heart of Ohio Family Health Centers™

Initial Health History (1 of 2)

NAME

DOB

MR #

HOSPITALIZATION & SURGERIES

Year	Hospital	Reason

FAMILY HISTORY

Relation	Living	Age/ Age at death	Medical Problems
Father	❑	______	______
Mother	❑	______	______
Brother	❑	______	______
Sister	❑	______	______

Check if any blood relative had: ❑ Asthma ❑ Allergies ❑ Cancer ❑ Chemical Dependency ❑ Depression ❑ Diabetes ❑ Heart Disease ❑ High Blood Pressure

SOCIAL HISTORY (Check if you use)

	How much	Quit when
❑ Alcohol	______	______
❑ Drugs	______	______
❑ Tobacco	______	______

PREVENTIVE CARE	last check up
❑ Dental	______
❑ Mammogram	______
❑ PAP	______
❑ Prostate Exam	______

IMMUNIZATION HISTORY (Check if immunized)

❑ Flu Year ______
❑ Hep B Year ______
❑ Pneumonia Year ______
❑ TB Year ______
❑ Tetanus Year ______

❑ ______ Year ______
❑ ______ Year ______
❑ ______ Year ______
❑ ______ Year ______
❑ ______ Year ______

MARITAL STATUS

❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Separated

Occupation ______

Nationality of origin ______

Number in household ______

NOTES ______

______

______

______

______

SIGNATURE ______ **DATE** ______

Heart of Ohio Family Health Centers™

Initial Health History (2 of 2)

NAME

DOB

MR #