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** _____