

HEALTH HISTORY ASSESSMENT

Date: _____ Primary Care Physician: _____

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone# _____ Work Phone # _____ Mobile Phone# _____

Email address: _____

Employer: _____ Occupation: _____

If retired, what was your previous occupation? _____

Gender:	Marital Status:	Ethnicity:	Race:	Preferred Language:
Male <input type="checkbox"/>	Single <input type="checkbox"/>	Hispanic/Latino <input type="checkbox"/>	Asian <input type="checkbox"/>	English <input type="checkbox"/>
Female <input type="checkbox"/>	Married <input type="checkbox"/>	Not Hispanic/Latino <input type="checkbox"/>	American Indian <input type="checkbox"/>	Spanish <input type="checkbox"/>
	Divorced <input type="checkbox"/>	Decline <input type="checkbox"/>	Black/African American <input type="checkbox"/>	Other _____
	Domestic Partner <input type="checkbox"/>		Native Hawaiian <input type="checkbox"/>	
	Widowed <input type="checkbox"/>		White/Caucasian <input type="checkbox"/>	
			Decline <input type="checkbox"/>	

How confident are you that you can manage and control any health problems or concerns?

- Very confident Somewhat confident Not confident

Do you have a healthcare proxy/legal guardian? _____ If so, please provide name _____

Do you have an advance directive? Living will Healthcare power of attorney No

If yes, please provide a copy for your health record. If no, do you have a specific end of life care preference?

Allergies (medicine, food, latex, etc.)/Reactions _____

Current Medications (Include medications taken for sleep and as a laxative)

Medication	Dose	Frequency Taken	Medication	Dose	Frequency Taken

List Previous and Current Conditions Being Treated for (ex. High blood pressure, diabetes): _____

List Surgeries/Hospitalizations with Dates: _____