

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: _____