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HEALTH ASSESSMENT

DATE: _____________ NAME:___________________________________

Reason for coming:____

List ALL doctors involved in your care and their specialty:

1. ______________________________________ 2. ______________________________________
3. ______________________________________ 4. ______________________________________
5. ______________________________________ 6. ______________________________________

List medical diagnosis/conditions:

1. ______________________________________ 2. ______________________________________
3. ______________________________________ 4. ______________________________________
5. ______________________________________ 6. ______________________________________

List surgeries and dates:

1. ______________________________________ 2. ______________________________________
3. ______________________________________ 4. ______________________________________
5. ______________________________________ 6. ______________________________________

List all your allergies: ____

Print pharmacy name, address, tel, fax ____

List prescription medications:

Name of drug	Dose (in mg)	#of times per day

List ALL your complaints:

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

5. ______________________ 6. ______________________

7. ______________________ 8. ______________________

Cigarettes: Never used Current smoker Previous smoker

Age started smoking ___ # of packs per day ____ Age quit smoking ___ (Total #of years____)

Do you currently drink alcohol? Yes How much: _____________ No

Did you drink alcohol in the past? Yes How much: _____________ No

Illicit Drugs:

____

Marital status: Married Single Divorced Widow

Who do you live with? Name: ____________ Relationship: ________ How many children: ____

Occupation: _______________ Place of Birth:___________ Year arrived in USA ___________

Date of last colonoscopy ________ mammogram _________ pap ________ psa _______

History of cancer in your immediate family ____

____

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Your signature: ____________________________ Date: ___________________

If completed by someone other than the patient:

Name: _____________________________ Relationship: ___________________

Physician signature: ____________________________ Date: __________________