PT NAME_____

General Health History Form

office use only

Height_____ Weight _____

Medication ALLERGIES_____

List of MEDICATIONS _____

_____

CURRENT AND PAST MEDICAL HX

BP / Thyroid / CAD / CHF / COPD / HIV / Hep A B C / RA / Cancer / Depression / Reflux / Asthma / Diabetes / Cholesterol / Stroke / Heart Attack / Kidney Failure / Dialysis / Migraines / Diverticulitis / Emphysema

OTHER:_____

SURGERY HX

Appendix / Gall Bladder / Heart / Pacemaker / Hip / Knee / Shoulder / Tonsils / Thyroid / Hernia / Back / CABG/ Breast / carpal tunnel / Gastric bypass / Hemorrhoidectomy / Anesthesia problems/ hysterectomy

OTHER:_____

_____

FAMILY HX

ARTHRITS /BLEEDING DISORDER / CANCER / DIABETES / HEART ATTACK / HEART DISEASE / OSTEOPOROSIS/ RA

OTHER:_____

_____

SOCIAL HX

MARRIED/ SINGLE / DIVORCED / WIDOWED_____

CURRENT SMOKER: YES / NO cigar OR cigarettes Amt: ☐ pck/ day YEAR started: _____

FORMER SMOKER: YES / NO YEAR quit:_____ Amt: ☐ packs # Years smoked:_____

ALCOHOL USE: YES / NO What?_____ DRINKS/DAY_____

EXERCISE: YES/NO How often? ☐ **/WEEK** TYPE of Exercise _____