Personal Health History

Name: _____

Gender: _____ Birth date: _____ Age: _____

Place of birth: _____ Ethnicity: _____

Medical History:

Previous operations Year Hospital

_____ _____ _____

_____ _____ _____

Previous injuries/medical conditions Year

_____ _____

_____ _____

Mental illnesses Year diagnosed

_____ _____

_____ _____

Current prescription and non-prescription medications

Medication Dose Duration on medication

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug allergies

Medication Reaction

_____ _____

_____ _____

Preventative Health History

Tobacco: Ever used: _____ No. of cigarettes per day: _____ No. of cigars per day: _____

No. of years you smoked: _____ Have you ever quit? _____

Alcohol: No. of drinks per week: _____ Have you ever quit? _____ Have you abused alcohol? _____

Drugs: Have you ever used drugs? _____ When was your last use? _____ Which drugs? _____

_____

_____

Exercise: Do you regularly exercise? _____ If yes, what type of exercise: _____

How often do you exercise per week? _____ Length of each session: _____

Seat-belt use: Yes _____ No _____

Diet: No. of meals each day: _____ No. of glasses of water each day: _____ No. of snacks each day: _____

No. of servings of fruit per day: _____ No. of servings of vegetables per day: _____

No. of servings of meat per day: _____ No. of servings of dairy products per day: _____

Smoke alarm in home: Yes: _____ No: _____

Gun: Do you keep a gun in the home? _____ If yes, is it locked? _____ Is it loaded? _____

Vaccinations:

Vaccination	Year of last vaccination
Tetanus/diphtheria	_____
Pneumococcal vaccine	_____
Influenza vaccine	_____
Measles, mumps, rubella	_____
Polio	_____
Varicella (chicken pox)	_____
Hepatitis A	_____
Hepatitis B	_____

Past and Current Physicians:

Primary Physician/Specialty	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Insurance:

Health insurance company: _____

Your identification no. _____

Phone number of insurance company: _____

Pre-admission phone number: _____

Source: American Medical Association. (1998). *Personal Health History* (http://www.ama-assn.org/insight/gen–hlth/per-hlth/phhmain.htm)