Nature Coast Center for Primary Care

Health History

Patient Name: _____ **Date of Birth:** _____

Reason for visit: _____

Please answer ALL questions to the best of your ability. If you are unsure of the answer, leave it blank.

Medications: (name, dosage and directions-please be specific-you can attach a separate list)

_____ _____

_____ _____

_____ _____

Personal History: (please circle Yes or No, if **Yes** specify when diagnosed)

Asthma	Yes_____	No	High Blood Pressure	Yes_____	No
Bleeding Disorder	Yes_____	No	High Cholesterol	Yes_____	No
Cancer	Yes_____	No	Kidney Disease	Yes_____	No
Diabetes	Yes_____	No	Liver Disease	Yes_____	No
Emotional Disorder	Yes_____	No	Stroke	Yes_____	No
Glandular Disorder	Yes_____	No	Tuberculosis	Yes_____	No
Heart Disease	Yes_____	No	Other _____		

Allergies: Yes or No Known Drug Allergies (if **Yes**, please specify below)

Medication: _____ _____ _____

_____ _____ _____

Environmental/Food: _____ _____ _____

_____ _____ _____

Have you had a blood transfusion? Yes or No If **Yes**: When? _____

OVER

Nature Coast Center for Primary Care

Health History

Surgical History: (what type of surgery and when)

_____ _____

_____ _____

Hospitalizations: (which hospital, when and the reason for admission/ER visit)

_____ _____

_____ _____

Family History: (if **YES**, please indicate which family member)

Asthma	Yes /No	Mother/Father/Sibling(s)	Genetic Disease	Yes/No	Mother/Father/Sibling(s)
Cancer	Yes /No	Mother/Father/ Sibling(s)	Heart Disease	Yes/No	Mother/Father/Sibling(s)
Diabetes	Yes/No	Mother/Father/ Sibling(s)	Stroke	Yes/No	Mother/Father/Sibling(s)

Social History:

Caffeine (drinks or caffeine containing drugs) Yes or No If Yes: How Much? _____

Tobacco Yes or No If Yes: How often do you use it? _____ How long used? _____

Alcohol Yes or No If Yes: How often do you use it? _____ What type? _____

Preventative Medicine: (list last date of completion if applicable)

Colonoscopy _____ Endoscopy _____ Mammogram _____

Bone Density _____ Pap Smear _____ PSA _____

Flu Vaccine _____ Zostavax _____ Pneumovax _____

Specialists: (name of physician and condition treated)

_____ _____

_____ _____

Patient (or Responsible Party) Signature _____

Date: _____