Convenient Care Family Medicine
Patient Health History

Patient Name:_____

Please circle any condition you have or have had:

Asthma	Ear infections	Kidney Disease
Allergies/Hayfever	Fatigue	Kidney Stones
Angina	Gallbladder Problems	Mental Illness
Anemia	Gout	Nervousness/Depression
Arthritis	Headache	Liver Disease
Back pain	Heart Failure	Osteoporosis
Bronchitis/Chronic	Hernia	Peptic Ulcers
Cancer	Hemorrhoids	Prostate Disease
Cough	Hiatal hernia	**No Medical Problems**
Diabetes	High Blood Pressure	Other_____
Diverticulitis	Indigestion/Heartburn	_____

HOSPITALIZATIONS

Year	**Hospital**	**Reason for stay**
/	/	
/	/	
/	/	
/	/	
/	/	

Have you ever had a blood transfusion? ____yes ____no

HEALTH HABITS
Check which substances you use and how much.

How Much?

_____Caffeine_____
_____Tobacco_____
_____Drugs_____
_____Alcohol_____
_____Other_____

MEDICATIONS AND DOSAGES

_____
_____
_____
_____
_____
_____

SURGERIES

Year

___Appendectomy_____
___Cholecysectomy_____
___C-Section_____
___Hemorrhoids_____
___Tonsillectomy_____
___Prostate_____
___Hysterectomy_____
___Other_____

FAMILY HISTORY
Circle any condition of any blood relative

Relationship

Arthritis, gout_____
Asthma, hay fever_____
Cancer_____
Drug dependency_____
Diabetes_____
Heart disease, stroke_____
High blood pressure_____
Kidney disease, TB_____
Other_____

ALLERGIES to medications or other substances

___None_____
_____

Patient Signature_____Date_____Reviewed by_____