STEAMBOAT MEDICAL GROUP

PATIENT HEALTH HISTORY FORM

PLEASE PRINT CLEARLY **DATE:**_____

NAME:_____**DATE OF BIRTH:**_____

MEDICATION ALLERGIES: ☐ NONE_____

OTHER ALLERGIES: ☐ NONE_____

CURRENT MEDICATIONS: ☐ NONE (USE BACK FOR ADDITIONAL MEDICATIONS)

NAME OF MEDICATION/ DOSE / FREQUENCY	NAME OF MEDICATION/ DOSE / FREQUENCY
_____/_____/_____	_____/_____/_____
_____/_____/_____	_____/_____/_____
_____/_____/_____	_____/_____/_____

TOBACCO USE: ☐ CURRENT SMOKER (CIRCLE ONE) CIGARETTE/PIPE/CIGAR/E-CIG ☐ FORMER ☐ NEVER

SMOKELESS TOBACCO: ☐ CURRENT USER (CIRCLE ONE) CHEW/SNUFF ☐ FORMER ☐ NEVER

MARIJUANA USE: ☐ NONE ☐ YES, TYPE:_____

OTHER DRUG USE:☐ NONE ☐ YES, TYPE:_____

ALCOHOL USE: ☐ NONE ☐ YES, TYPE:_____AMOUNT PER WEEK:_____

SURGERIES: ☐ NONE ☐ YES, TYPE/DATE:_____

_____

_____

_____

MEDICAL HISTORY: ☐ NONE (CIRCLE IF YOU HAVE CURRENT OR PREVIOUS HISTORY)

ANEMIA	COPD	HERPES	MIGRAINES
ANXIETY	DEPRESSION	HIGH CHOLESTEROL	STROKE
ACID REFLUX	DIABETES	HIGH BLOOD PRESSURE	STOMACH ULCERS
CANCER	DIVERTICULOSIS	HIV/AIDS	THYROID DISEASE
CROHN'S DISEASE	EPILEPSY	HEPATITIS	TUBERCULOSIS
COLITIS	GLAUCOMA	KIDNEY DISEASE	
CATARACTS	HEART DISEASE	OTHER:_____	

FAMILY HISTORY: ☐ NONE (CHECK ALL THAT APPLY, LIST AGE DIAGNOSED IF KNOWN) ☐ ADOPTED

	ALIVE	DECEASED	CANCER	HEART DISEASE	STROKE	HIGH CHOLESTEROL	HIGH BLOOD PRESSURE	DIABETES	DEPRESSION	ANXIETY	THYROID DISEASE	ASTHMA	COPD	ALZHEIMERS	OTHER	OTHER
MOTHER																
FATHER																
SISTER																
BROTHER																
DAUGHTER																
SON																
MATERNAL GM																
MATERNAL GF																
PATERNAL GM																
PATERNAL GF																
OTHER																
OTHER																