Comprehensive Health History

Patient Name: _________________________ DOB: _________ Date: _______

Current Medications & Supplements

Include dosage and frequency if known.

1. ___________________________________
2. ___________________________________
3. ___________________________________
4. ___________________________________

Allergies

List medication, food, or environmental allergies and your reaction (e.g., hives, swelling).

- [ ] No Known Drug Allergies (NKDA)
- ___________________________________
- ___________________________________
- ___________________________________

Medical History

Check all that apply to you: [ ] Hypertension [ ] Diabetes [ ] Heart Disease [ ] Asthma/COPD [ ] Anxiety/Depression [ ] Cancer (Type:_______) [ ] Thyroid Issues [ ] High Cholesterol [ ] Chronic Pain [ ] Other:

____

Surgical & Hospitalization History

List major surgeries or hospital stays and the approximate year:

1. ___________________________________
2. ___________________________________
3. ___________________________________
4. ___________________________________

Family History

Has any immediate family member (parents/siblings) had:

- **Heart Disease/Stroke:** [ ] Yes [ ] No
- **Cancer:** [ ] Yes (Type:_______) [ ] No
- **Diabetes:** [ ] Yes [ ] No

Lifestyle & Social History

- **Tobacco Use:** [ ] Never [ ] Former [ ] Current (___ packs/day)
- **Alcohol:** [ ] None [ ] Occasional [ ] Daily (___ drinks/week)
- **Drug Use:** Yes/No **If yes (type): ______________________**
- **Occupation:** _____________________ **Exercise Level:** [ ] Low [ ] Mod [ ] High

Previous Medical Provider

- **Name of Provider and Practice: _____________________**
- **When were you last seen?_____________________**
- **Do you see any specialists?** Yes/No
- **If yes, Name of Provider and Practice: ________________**

General Consent to Treat

Authorization for Care

I, the undersigned, hereby voluntarily consent to medical evaluation, testing, and treatment provided by [Your Name/Practice Name]. I understand that this may include physical exams, diagnostic tests (e.g., blood draws, EKGs), and minor procedures.

No Guarantee of Results

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the outcome of any examination or treatment.

Patient Participation

I understand that my active participation and honesty regarding my medical history, symptoms, and lifestyle are essential to receiving safe and effective care.

Mental Health & Sensitive Data

I authorize the provider to document and maintain records regarding my physical and mental health. (Note: Specific HIPAA releases apply for sharing this data with third parties).

Acknowledgement: I have read this form (or had it read to me) and I fully understand its contents. I certify that I am the patient or the patient's legal representative.

Patient/Guardian Signature: ______________________________ **Date:** ____________ **Print Name:** ____