GRETNA FAMILY HEALTH
Health . Wellness . Beauty

Patient Health History

NAME - LAST	FIRST	MIDDLE	DOB	TODAY DATE

DRUG ALLERGIES (PLEASE INCLUDE REACTION)

CURRENT MEDICATIONS (PLEASE INCLUDE DOSING AND FREQUENCY)

FOOD / ENVIRONMENTAL ALLERGIES (PLEASE INCLUDE REACTION)

PREFERRED PHARMACY (PLEASE INCLUDE LOCATION)

PREVENTATIVE CARE

	WHEN	WHERE
MAMMOGRAM		
COLON/COLO-GUARD		
EYE EXAM/DIABETIC		
DENTAL EXAM		

WOMEN ONLY

PREGNANT HYSTERECTOMY BIRTH CONTROL

DATE OF LAST PAP _____ METHOD _____

OF PREGNANCIES _____ # OF LIVE BIRTHS _____

SOCIAL HISTORY (PLEASE CHECK ALL THAT APPLY)

SINGLE MARRIED DIVORCED WIDOWED

OCCUPATION _____ EMPLOYER _____

TOBACCO: NON-SMOKER FORMER CURRENT - # OF CIGS A DAY _____ VAPE

CIGAR PIPE CHEWING TOBACCO

CAFFEINE - DRINK PER DAY _____ ALCOHOL - DRINKS PER WEEK _____ MONTH _____

STREET DRUGS CURRENT FORMER TYPE(S) _____ HOW LONG _____

SURGICAL HISTORY

PROCEDURE	YEAR

PERSONAL MEDICAL HISTORY (CHECK IF YOU HAVE OR HAD ANY OF THE FOLLOWING)

- HIGH BLOOD PRESSURE
- STROKE
- HEART ATTACK
- CONGESTIVE HEART FAILURE
- HIGH CHOLESTEROL
- ASTHMA
- EMPHYSEMA
- DIABETES
- ANEMIA
- CHRONIC SINUSITIS
- ANXIETY
- ARTHRTIS
- THYROID DISEASE
- SEIZURES
- ALCOHOLISM
- DEPRESSION
- PSYCHIATRIC DISORDER
- PROSTATE DISEASE
- GOUT
- CLOTTING DISORDER
- HEADACHES
- KIDNEY DISEASE
- LIVER DISEASE
- OSTEOPOROSIS
- LUPUS
- STOMACH ULCERS
- CANCER TYPE _____
- OTHER _____

FAMILY HISTORY (CHECK BOX(ES) WHICH APPLY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	OTHER
HEART DISEASE						
HIGH BLOOD PRESSURE						
HIGH CHOLESTEROL						
STROKE						
CANCER						
DIABETES						
KIDNEY DISEASE						
BLEEDING DISORDER						
EPILEPSY						