Health History Form

Thank you for choosing Manhattan's Physician Group for your medical treatment. Below is a form that will help us have a more informed background of your medical history. Please complete this form to the best of your recollection.

Patient Demographic Information			
First Name:	Middle Initial:	Last Name:	
Birth Date: / /		Sex: Male / Female	SS #:
Previous Primary Care Physician:			

Allergies	
☐ NKDA (No Known Drug Allergies)	
Allergy	**Reaction**
	☐ Hives ☐ Itching ☐ Other: ___________________
	☐ Hives ☐ Itching ☐ Other: ___________________
	☐ Hives ☐ Itching ☐ Other: ___________________
	☐ Hives ☐ Itching ☐ Other: ___________________

Past Medical History				
		Condition	**Start Date**	**Details**
☐ Yes	☐ No	Anemia		
☐ Yes	☐ No	Arthritis		
☐ Yes	☐ No	Asthma		
☐ Yes	☐ No	Back Problem(s)		
☐ Yes	☐ No	Blood Clot		
☐ Yes	☐ No	Broken Bones		
☐ Yes	☐ No	Bronchitis		
☐ Yes	☐ No	Depression		
☐ Yes	☐ No	Diabetes		
☐ Yes	☐ No	Gastric Problem(s)		
☐ Yes	☐ No	Headaches		
☐ Yes	☐ No	Heart Problem(s)		
☐ Yes	☐ No	HIV / AIDS		
☐ Yes	☐ No	Hypertension		
☐ Yes	☐ No	Kidney Disease		
☐ Yes	☐ No	Liver Disease		
☐ Yes	☐ No	Skin Problem(s)		
☐ Yes	☐ No	Stroke(s)		
☐ Yes	☐ No	Thyroid Disease		
☐ Yes	☐ No	Urinairy Problem(s)		

Surgical History

☐ No Surgeries Performed

Surgery	Details

Family History

Family Member	Status	Cause of Death
Mother	__ Alive / Age: ____; __Deceased / Age:	
Father	__ Alive / Age: ____; __Deceased	
Sibling: ________________________	__ Alive / Age: ____; __Deceased	
Sibling: ________________________	__ Alive / Age: ____; __Deceased	
Sibling: ________________________	__ Alive / Age: ____; __Deceased	
Sibling: ________________________	__ Alive / Age: ____; __Deceased	

OB GYN History

☐ Not Applicable

Number of Abortions: ____

Number of Miscarriages: ____

Number of Ectopic / Tubal Pregnancies: ____

Age of first period: _____

Date of last Mammogram: ______________

Abnormal Mammogram: ☐ Yes ☐ No

Contraception Method: __________________not applicable

Ovarian Cysts: ☐ Yes ☐ No

Date of last Pap Smear: ______________

Abnormal Pap Smear: ☐ Yes ☐ No

Social History

Occupation: _______________________________________ ☐ Full Time ☐ Part Time ☐ Temporary ☐ Retired

Spousal Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Children: ☐ Yes ☐ No If applicable: ____ Number of Male ____ Number of Female

Pets: ☐ Yes ☐ No Please specify (if applicable) : ____

Religious Affiliation: _______________ **Sexually Active:** ☐ Yes ☐ No Number of Partners: ____

History of STD(s): ☐ Yes ☐ No Please specify (if applicable) : ______________________________________

Tobacco Use: ☐ Yes ☐ No ☐ Former Passive Exposure ☐ Quit: Amount of Time: _________

Type of Tobacco Use: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Other: ____________

Frequency of Use: Amount / Day: ________ How long: _____________

Alcohol Use: ☐ Yes ☐ No Frequency: ________ Amount: _____________

Recreational Drugs ☐ Yes ☐ No Type(s): _______________________ ☐ Quit: Amount of Time: _________

Advanced Directives: ☐ DNR ☐ Living Will ☐ Health Care Proxy ☐ Power of Attorney

____ ___________

Patient Signature Date