



Saint Alphonus Medical Group

Annual Health History Page 2

Medications and dosages:	Allergies:
1.	
2.	
3.	
4.	Hospitalizations:
5.	1. _____ 2. _____
6.	3. _____ 4. _____
7.	5. _____ 6. _____
8.	Surgeries:
Injuries:	

Immunizations: When did you last have?

Immunizations: Tetanus _____ Pneumonia _____ Flu _____ TB _____ Hepatitis B _____ Other _____

Family History (Circle Cause of Death As Applicable)

	Father	Mother	Brothers	Sisters		Father	Mother	Brothers	Sisters
Heart Failure (Weak Heart)					Thyroid Disease				
High Blood Pressure (Hypertension)					Glaucoma				
Heart Attack or Angina					Osteoporosis				
Stroke					Migraine Headaches				
High Cholesterol					Depression				
Diabetes					Trouble with blood not clotting properly				
Emphysema					Cancer				
Asthma					Alcoholism				
Cause of death					Age at Death				

Social History

Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/>	Diet: Unrestricted <input type="checkbox"/> Low fat <input type="checkbox"/> Low carb/diabetic <input type="checkbox"/> Caffeine: Yes <input type="checkbox"/> No <input type="checkbox"/> Type/Amt.:	Exercise: Yes <input type="checkbox"/> No <input type="checkbox"/> Type: _____ Once a week <input type="checkbox"/> 2-3x/wk <input type="checkbox"/> Daily <input type="checkbox"/>
Occupation: Years of Education-Degree _____	Sleep: # of Hours _____ Problems: Falling asleep: Yes <input type="checkbox"/> No <input type="checkbox"/> Staying asleep: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Spouse's Name: _____ Occupation: _____	Ages of Children	Do you have a living will? Yes <input type="checkbox"/> No <input type="checkbox"/>
Tobacco: <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never Started: _____ Quit: _____ Packs per day? _____	Alcohol: <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never # of drinks per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	Street Drugs: <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never What? _____ Started: _____ Quit: _____

Name: _____
DOB: _____