

Health history

This helps your provider start well informed. Answer what you can. Your provider will go through it with you, and nothing here is a test.

Patient name

Date of birth

Medicines, vitamins and supplements

Name

Dose

How often

Name

Dose

How often

Name

Dose

How often

Name

Dose

How often

Allergies

Medicine, food or other

What happens

Medicine, food or other

What happens

I have no known allergies

☐ No known allergies

Health conditions you have, or have had

Check all that apply

☐ Asthma or lung disease

☐ Diabetes

☐ High blood pressure

☐ High cholesterol

☐ Heart disease

☐ Thyroid condition

☐ Depression or anxiety

☐ Cancer

☐ Kidney disease

☐ Migraines

☐ Arthritis

☐ Other (write below)

Other conditions, and operations or hospital stays with the year

Family history

Check any that a parent, brother or sister has had

- | | | |
|--|--|--|
| ☐ Heart disease | ☐ Stroke | ☐ Diabetes |
| ☐ Cancer | ☐ High blood pressure | ☐ Mental health condition |

Details, such as who and at what age

Daily life

Tobacco or vaping

- | | | |
|--------------------------------|----------------------------------|------------------------------|
| ☐ Never | ☐ Used to | ☐ Now |
|--------------------------------|----------------------------------|------------------------------|

Alcoholic drinks in a typical week

Days of exercise in a week

Hours of sleep a night

For patients who may be pregnant, or who are planning a pregnancy

First day of your last period

Number of pregnancies

Number of births

Anything else you would like your provider to know
