Health History

Professional Village Medical Center
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John S. DeMare, D.O.
Joyce A. McDonald, D.O.
Steven R. Shepherd, D.O.
Frank A. DiPonio, D.O.

Name: _____ **Date of Birth:** _____

Race: American Indian Alaskan Native Asian White Native Hawaiian African American Multiple Races Other Pacific Islander Undefined/Unknown Refuse to Answer

Ethnicity: Hispanic (or Latino) Non-Hispanic Unknown Refuse to Answer

Primary Language (Language Most Used): _____

E- Mail Address: _____

Allergies – Please list all below along with what type of reaction occurs:

Medication Allergies: _____

_____

_____

Food Allergies: _____

Contactant Allergies: _____

Environmental Allergies: _____

Immunizations – Please answer all below:

(Also, if there is an existing copy of immunization records, please provide to our office)

Are you up to date? Yes No

Have you had your…….

Pneumonia Vaccination? Yes No **If so, when?** _____

Shingles Vaccination? Yes No **If so, when?** _____

Flu Vaccination? Yes No **If so, when?** _____

Tetanus Vaccination? Yes No **If so, when?** _____

Did the Tetanus Vaccination include a Pertussis Vaccination? Yes No

Personal Medical History – Please answer all below based on your own health history:

Cancer:	**Yes**	**No**	**What kind?**_____
Diabetes:	**Yes**	**No**	**What kind?**_____
Thyroid Disease:	**Yes**	**No**	**What kind?**_____
Stroke:	**Yes**	**No**	
Heart Disease:	**Yes**	**No**	
Heart Attack:	**Yes**	**No**	
Heart By-pass:	**Yes**	**No**	
High Cholesterol:	**Yes**	**No**	
High Blood Pressure:	**Yes**	**No**	
Asthma:	**Yes**	**No**	
Anemia:	**Yes**	**No**	
COPD:	**Yes**	**No**	

Please list any other past medical conditions not mentioned above: _____

_____

_____

_____

Family History – Please answer all based on your family history:

Cancer: **Yes** **No** **If so, who and what kind?** _____

High Cholesterol: **Yes** **No** **If so, who?** _____

Diabetes: **Yes** **No** **If so, who and what kind?** _____

Heart Disease: **Yes** **No** **If so, who?** _____

Heart Attack: **Yes** **No** **If so, who?** _____

Heart By-pass or Stent: **Yes** **No** **If so, who?** _____

Stroke: **Yes** **No** **If so, who?** _____

Thyroid Disease: **Yes** **No** **If so, who and what kind?** _____

High Blood Pressure: **Yes** **No** **If so, who?**_____

Is your family medical history unknown? **Yes** **No** **Are you adopted?** **Yes** **No**

Please list any other family medical history not mentioned above: _____

_____

_____

Last Exam Dates (if applicable) – Please list all previous exams and dates below: (Also, if you have any copies of these records, please provide to office)

Bone Density: _____ **Colonoscopy:**_____

Stress Test: _____ **Complete Physical:** _____

Eye Exam: _____ **How often do you get eye examinations?** _____

Dental Exam: _____ **How often do you get dental examinations?** _____

Mammogram: _____ **Pap Smear:** _____

How many pregnancies have you had? _____ **How many live births/ children have you had?** _____

Social History – Please provide information on social habits below:

Do you exercise regularly? _____ **How often?** _____

What form of exercise do you do?_____

Do you use any drugs? Yes No If so, what kind of drugs?_____

Do you drink alcohol? Yes No If so, what kind of alcohol? _____

How often do you drink?_____ **How much do you consume?** _____

Are you a smoker? Yes No How much do you smoke? _____

What do you smoke? _____ **How long have you been smoking?** _____

Are you a past smoker? Yes No How many years did you smoke? _____

How long ago did you quit? _____

Are you regularly exposed to tobacco smoke? Yes No

Do you drink caffeine? Yes No How many cups a day do you consume?_____

What do you drink that has caffeine in it? _____

Travel History

Have you traveled outside of the country in the last 6 months? Yes No

If so, where have you traveled? _____

Surgical History – Please list all previous surgical procedures below:

_____

_____

_____

_____

Medication List – Please list any current medications being taken, including all over the counter products. Please list when you take it, what the dosage is, and how often you take it. If the prescription is managed by another physician, please list who that doctor is below as well.

If you are a new patient, please bring your actual medication bottles to your appointment.

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBING DR.