Patient Name: _____ Date Birth: _____ Referred By: _____

Patient Health History

Thank-you for selecting GCH Clinics

As a new patient to our practice, please fill out the information below so we may provide you with the highest level of healthcare.

Past Medical History: Have you ever had the following – **(Please circle either yes or no)**

Diabetes	Yes	No		Measles	Yes	No		Headaches	Yes	No		Lung Disease	Yes	No
Cancer	Yes	No		Mumps	Yes	No		Tuberculosis	Yes	No		Stroke	Yes	No
High Blood Pressure	Yes	No		Chickenpox	Yes	No		Blood Transfusion	Yes	No		Heart Valve Disease	Yes	No
Asthma	Yes	No		Scarlet Fever	Yes	No		Hernia	Yes	No		Anemia	Yes	No
Allergies	Yes	No		Pneumonia	Yes	No		Glaucoma	Yes	No		Hepatitis	Yes	No
Stomach Ulcer	Yes	No		Rheumatic Fever	Yes	No		Hemorrhoid	Yes	No		Blood Clots	Yes	No
Anxiety or Depression	Yes	No		Sexually Trans. Disease	Yes	No		Spine Trouble	Yes	No		Bleeding Tendency	Yes	No
Thyroid Disease	Yes	No		Urine Infections	Yes	No		Hives / Eczema	Yes	No		Other Diseases:		
Heart Disease	Yes	No		Epilepsy/Seizure	Yes	No		AIDS / HIV+	Yes	No				
Arthritis	Yes	No		Sleep Apnea	Yes	No		Kidney Disease	Yes	No				

Previous Surgeries: (Please List) _____

(Examples include: Tonsils, Back, Hernia, Appendix, Gall Bladder, Cervix, Colon, etc.)

Medications: (include non-prescription)

Name of Medication	Strength	How Often		Name of Medication	Strength	How Often

Allergies to Medications: _____ **Allergies to Other: _____**

Routine Immunizations: (Please indicate the year in which you last had the following)

Tetanus Shot _____ Flu Shot _____ Hepatitis B Shot _____ Meningitis Shot _____

Varicella (chicken pox) Shot _____ Pneumonia Shot _____ Zostavax (shingles) Shot _____ HPV Shot _____

Routine Screenings: (Please indicate the year in which you last had the following and any abnormalities)

Eye Exam _____ Dental Exam _____ Bone Density (DEXA) _____ Colonoscopy _____

PSA test (men only) _____ Pap Smear (women only) _____ Mammogram _____

Female Patients Only: Menses: Age Onset _____ How Often _____ Last Menstrual Period _____

Pregnancies: Number _____ Living Children _____ Miscarriages _____ Abortions _____

Social History:

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	Drinks per day: _____
Use of Tobacco:	Never	Previously, but quit		Current	Packs per day: _____
Use of Drugs:	Never	Current	Type / Frequency _____		
Caffeine:	Never	Current – type/frequency per day _____			
Exercise:	Never	Current – type / frequency per week _____			

Family Medical History:

	Age	Diseases	If Deceased, Age and Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____