Allergies (Please list all foods, drugs, etc., that you are allergic to):

_____

_____

_____

_____

Patient Social History:

Use of Alcohol: Never_____ Rarely_____ Moderate_____ Daily_____
Use of Tobacco: Never_____ Previously, but quit_____ Currently (packs/day)_____
Use of Drugs: Never_____ Type/Frequency_____

Excessive Exposure at home to: Fumes_____ Dust_____ Solvents_____ Air-borne Particles: _____

Hobbies: _____
Exercise/Recreation: _____

Family Medical History:

Has any blood relative had any of the following: (please mark "yes" or "no")

___	___	Cancer	_____	___	___	Tuberculosis	_____
___	___	Diabetes	_____	___	___	Heart Disease	_____
___	___	High Blood Pressure	_____	___	___	Stroke	_____
___	___	Epilepsy	_____	___	___	Allergies	_____
___	___	Anemia	_____	___	___	Bleeding Tendency	_____
___	___	Asthma	_____	___	___	Chronic Lung Disease	_____
___	___	Mental Illness	_____	___	___	Leukemia	_____
___	___	Migraine Headaches	_____	___	___	Obesity	_____
___	___	Thyroid Disease	_____	___	___	Ulcer	_____
___	___	Depression	_____	___	___	High Cholesterol	_____
___	___	Kidney Disease	_____	___	___	Gout	_____
___	___	Glaucoma	_____	___	___	Cataracts	_____
___	___	Drug/Alcohol Problem	_____	___	___	Retinal Problems	_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

_____ _____
Signature of Patient/Parent/Guardian Date

Guardian's Relationship to Patient: _____

This Health History has been reviewed in its entirety with the patient.

_____ _____ _____
Signature of Professional Title Date