JOHN MUIR HEALTH
John Muir Physician Network

HEALTH HISTORY FORM

Name: Date of Birth:

Medical History

Question	Response	Date first noted (approx)	Comments
Allergies	☐ Yes ☐ No		
COPD/chronic bronchitis	☐ Yes ☐ No		
Lung cancer	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No		
Dementia	☐ Yes ☐ No		
Migraines	☐ Yes ☐ No		
Anxiety	☐ Yes ☐ No		
Depression	☐ Yes ☐ No		
Myocardial infarction	☐ Yes ☐ No		
Arthritis	☐ Yes ☐ No		
Diabetes mellitus	☐ Yes ☐ No		
Nerve/muscle disease	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No		
Eye Disease	☐ Yes ☐ No		
Brittle bones	☐ Yes ☐ No		
Autoimmune Disease	☐ Yes ☐ No		
Acid reflux	☐ Yes ☐ No		
Prostate cancer	☐ Yes ☐ No		
Bipolar disorder	☐ Yes ☐ No		
Glaucoma	☐ Yes ☐ No		
Seizures	☐ Yes ☐ No		
Breast cancer	☐ Yes ☐ No		
Gout	☐ Yes ☐ No		
Skin cancer	☐ Yes ☐ No		

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HEALTH HISTORY FORM

Name: Date of Birth:

Medical History (continued)

Question	Response	Date first noted (approx)	Comments
Cancer	☐ Yes ☐ No		
Heart Murmur	☐ Yes ☐ No		
Sleep apnea	☐ Yes ☐ No		
Cardiovascular other	☐ Yes ☐ No		
Hyperlipidemia	☐ Yes ☐ No		
Stroke/CVA	☐ Yes ☐ No		
Celiac disease	☐ Yes ☐ No		
High blood pressure	☐ Yes ☐ No		
Substance abuse	☐ Yes ☐ No		
Congestive heart failure	☐ Yes ☐ No		
Kidney disease	☐ Yes ☐ No		
Thyroid disease	☐ Yes ☐ No		
Bleeding problem	☐ Yes ☐ No		
Kidney stones	☐ Yes ☐ No		
Tremors	☐ Yes ☐ No		
Colon cancer	☐ Yes ☐ No		
Leukemia	☐ Yes ☐ No		
Ulcers	☐ Yes ☐ No		

Surgical History

Question	Response	Occurrence date (approx)	Comments
Appendectomy	☐ Yes ☐ No		
Dental surgery	☐ Yes ☐ No		
Prostate surgery	☐ Yes ☐ No		
Vasectomy	☐ Yes ☐ No		

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HEALTH HISTORY FORM

Name: Date of Birth:

Surgical History (continued)

Question	Response	Occurrence date (approx)	Comments
Brain surgery	☐ Yes ☐ No		
Eye surgery	☐ Yes ☐ No		
Small intestine surgery	☐ Yes ☐ No		
Vein surgery	☐ Yes ☐ No		
Breast surgery	☐ Yes ☐ No		
Foot surgery	☐ Yes ☐ No		
Spine surgery	☐ Yes ☐ No		
Heart bypass	☐ Yes ☐ No		
Fracture surgery	☐ Yes ☐ No		
Thyroid surgery	☐ Yes ☐ No		
Gall bladder removal	☐ Yes ☐ No		
Hernia repair	☐ Yes ☐ No		
Tonsillectomy	☐ Yes ☐ No		
Colon/large intestine surgery	☐ Yes ☐ No		
Hysterectomy	☐ Yes ☐ No		
Tubes tied	☐ Yes ☐ No		
Plastic surgery	☐ Yes ☐ No		
Joint replacement	☐ Yes ☐ No		
Ear tubes	☐ Yes ☐ No		
C-Section	☐ Yes ☐ No		
Ovary removal	☐ Yes ☐ No		
Heart valve replacement	☐ Yes ☐ No		

HEALTH HISTORY FORM

Name: Date of Birth:

Family History

Item	Family Member (i.e. mother, father)	Name	Comments
Allergies			
Anxiety/Depression			
Arthritis			
Asthma			
Breast cancer			
Clotting disorder			
Colon cancer			
COPD			
Crohn's/Ulcerative Colitis			
Dementia			
Diabetes			
Glaucoma			
Heart disease			
Hyperlipidemia			
Hypertension			
Kidney disease			
Learning disabilities			
Lung cancer			
Macular degeneration			
Mental retardation			
Migraines			
Osteoporosis			
Ovarian cancer			
Prostate cancer			

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HEALTH HISTORY FORM

Name: Date of Birth:

Family History (continued)

Item	Family Member (i.e. mother, father)	Name	Comments
Skin cancer			
Stroke			
Thyroid disease			

Social History

Alcohol Use ☐ Yes ☐ No

Drinks/Week
☐ Glasses of wine
☐ Cans of beer
☐ Shots of liquor
☐ Drinks containing 0.5 oz of alcohol

Comments

Tobacco Use ☐ Current Everyday Smoker ☐ Current Some Day Smoker ☐ Never ☐ Former Smoker ☐ Passive

Packs/Day
☐ 0 ☐ 0.25 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 3
☐ Other (specify here)

Years
☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35
☐ 40 ☐ Other (specify here)

Quit Date

Comments on your history with tobacco:

Drug Use ☐ Yes ☐ No