

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



JOHN MUIR
HEALTH

John Muir Physician Network

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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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		



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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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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