MORELAND FAMILY MEDICINE ASSOCIATES
717 WEST MORELAND BOULEVARD • WAUKESHA, WISCONSIN 53188
PHONE 262-542-9100 FAX 262-542-7366

HEALTH HISTORY FORM

Name: ____ DOB: ______________________________ AGE: ____________

Please answer the following questions to the best of your ability. If you do not understand the question, please leave it blank. Thank you.

Have you or any of your family members ever had the following?

	Yourself	Mother	Father	Other
Cancer (please list type)				
Diabetes				
Anemia				
Heart Disease or Heart Attack				
Mitral Valve Prolapse				
Rheumatic Fever				
High Blood Pressure				
Kidney Disease (kidney stones, kidney failure, etc).				
Liver Disease (hepatitis, cirrhosis, etc.)				
Lung Disease (emphysema, TB, asthma, etc.)				
Seizures				
Strokes				
Environmental Allergies				
Thyroid Disorder				
Mental Health Disease (depression, anxiety, eating disorder, etc.)				
Alcohol or Drug Abuse				

Are you taking any medications at the present time? If yes, please list name of medication(s) and dosage.

Do you have any allergies to medications? Please list medication name and reaction.

Have you had any surgical procedures? Please list (include date).

____ ____
____ ____
____ ____
____ ____

Do you smoke? YES ___ NO ___

Cigars? ______

Pipe? ______

Cigarettes? ______

Chewing Tobacco? ______

How Much/Often? __________________

Do you drink alcohol? YES ___ NO ___

How much in a typical week? ____________________________

Do you wear seat belts? YES ___ NO ___

Marital Status: ______ Married ______ Single ______ Widowed ______ Divorced

Do you have any children? If so, names and ages.

____ ____
____ ____

Date of last tetanus shot: ____

Date of last pneumonia (pneumococcal) shot: ____

Have you ever had chickenpox? YES ___ NO __ Date of vaccination: ____

Date of last colonoscopy: ______________________________ or flexsig/BE: ____

Women Only

Date of last mammogram: ________________________________

Date of last Pap: ____

Date of last bone density test: _____________________________

Men Only

Date of last PSA test: _____________________________________