Spring Grove Family Care Center **CONFIDENTIAL HEALTH HISTORY**

Name: _____ Birthdate: _____ Date: _____

Reason for visit: _____ Occupation: _____

Medications	Medical Problems

Allergies: _____

Surgeries/Hospitalization	**Health Habits** , circle answer, please give amounts
	Tobacco no yes
	Alcohol no yes
	Caffeine no yes
	Drugs no yes

Family History

Relation	Age	Health status	Cause of Death
Mother			
Father			
Siblings			

Any blood transfusions? No Yes When? _____

Do you a living will ? No Yes

When was your last physical exam? _____

How well do you sleep? _____

Last tetanus shot? _____

Occupational Exposures (please circle): loud noise heat vibrations

Do you have any pains? No Yes If so, where? _____

Who do you live with? _____

Do you have any other concerns/information we should know? _____

_____

_____

_____ _____

Signature Date

_____ _____

Reviewed by Date