



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



HEALTH HISTORY FORM

Name:

Date of Birth:

Medical History (continued)

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

Surgical History

Question	Response	Occurrence date (approx)	Comments
Appendectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>
Dental surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>
Prostate surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>
Vasectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>



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Surgical History (continued)

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



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HEALTH HISTORY FORM

Name:

Date of Birth:

Family History

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



HEALTH HISTORY FORM

Name:

Date of Birth:

Family History (continued)

Item	Family Member (i.e. mother, father)	Name	Comments
Skin cancer	<input type="text"/>	<input type="text"/>	<input type="text"/>
Stroke	<input type="text"/>	<input type="text"/>	<input type="text"/>
Thyroid disease	<input type="text"/>	<input type="text"/>	<input type="text"/>

Social History

Alcohol Use

Drinks/Week

Yes No

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