Cornerstone Family Care, PC

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HEALTH ASSESSMENT FORM

MEDICAL HISTORY

Name (Last, First, Middle Initial)	Date of Birth	Todays Date:

Personal Medical History: Have you ever been diagnosed with any of the following? Please Check Where Applicable

Alcohol Abuse	Fibrocystic Breast Disease	Obesity
Arthritis	Fractures: Where:	Osteoporosis/Osteopenia
Bipolar Disorder	Heart Attack/MI	Parkinson's Disease
Cancer: Type:	Heart Disease/Coronary Artery Disease	Stroke/CVA
Crohn's Disease	Hepatitis C	
Deafness	High Cholesterol	
Depression	HIV Infection	
Diabetes Mellitus, Type I	HPV	
Diabetes Mellitus, Type II	Hypertension/High Blood Pressure	

Allergy History:

Medication Allergy: _____ Reaction: _____
Medication Allergy: _____ Reaction: _____
Medication Allergy: _____ Reaction: _____

Foods	Contactants	Environmental Allergens
Avocado - Reaction	Adhesive Tape – Reaction	Cockroaches – Reaction
Chocolate – Reaction	Betadine – Reaction	Dust – Reaction
Egg White – Reaction	Chemicals – Reaction	Insect Bites/Stings – Reaction
Licorice – Reaction	Cosmetics – Reaction	Mites - Reaction
Milk – Reaction	Detergent/Soap – Reaction	Mold Spores - Reaction
Nuts – Reaction	Feathers – Reaction	Pollens - Reaction
Peanuts – Reaction	Latex - Reaction	Trees - Reaction
Seafood - Reaction	Metal - Reaction	Cat Hair – Reaction
Shellfish - Reaction	Nickel - Reaction	Dog Hair - Reaction
Wheat - Reaction	Poison Ivy – Reaction	Smoke - Reaction
	Wool - Reaction	

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Immunization History: If you have received the following immunizations, Please State the Year.	
Tetanus: Year:	Flu: Year:
Pneumonia: Year:	Hepatitis Injections: Year:
Gardasil: Year:	

Family History: THIS MEANS ANYONE OTHER THAN YOURSELF!! Please state Family Member and denote if Maternal or Paternal, Living or Deceased.	
Alcohol Abuse	Diabetes Mellitus, Type I
Arthritis	Diabetes Mellitus, Type II
Bipolar Disorder	Fibrocystic Disease of the Breast
Cancer: Type:	Fractures
	Heart Attack/MI
	Heart Disease/Coronary Artery Disease
	Hepatitis C
	High Cholesterol
Crohn's Disease	HIV Infection
Deafness	HPV
Depression	Hypertension/High Blood Pressure
	Obesity
	Osteoporosis/Osteopenia
	Parkinson's Disease
	Stroke/CVA

Social History:
Occupation:
Exercise History: Do you exercise? _____ How Often? _____
Caffeine Usage: Do you drink tea or soda with caffeine? _____ How much per day? _____
Tobacco Usage: Have you ever smoked? _____ Do you currently smoke? _____ How much per day? _____ How long have you smoked? _____ When did you quit smoking? _____
Alcohol Usage: Do you drink alcohol? _____ How much per day? _____ Per week? _____
Drug Usage: Have you ever used illegal drugs? _____ Do you currently use illegal drugs? _____ Name of Drug _____ How often? _____

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Medications: Please list ALL current medications – prescription and non-prescription – including over the counter vitamins/herbs.

Name of Drug	Strength	# tablets taken	# times per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Women's Health:

Last Menstrual Period: _____	Breast Surgery: YES or NO	Abnormal Pap (provide date)_____	
Pregnancies: # _____	Miscarriages: # _____	Abnortion: # _____	Live Births: # _____
Hysterectomy: Total: YES or NO Partial: YES or NO		Tubal Ligation: (date) _____	

Surgeries: Have you had any of the following surgeries? Please state the year.

Appendectomy	Hernia Repair
Breast Enhancement	Hysterectomy
Cataract	Mastectomy/Breast
Caesarean Section	Thyroidectomy
Coronary Artery Bypass	Tonsillectomy
Gallbladder	Tubal
Gastric Bypass/Weight Loss	Vasectomy
Other Surgeries	

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Health Maintenance History: **If you have received the following maintenance testing, please state the date received.**	
Bone Mineral Density	Mammogram
Colonoscopy	Pap Smear
Dental Exam	Abnormal Pap Smear
EGD	PSA
Eye Exam	Stress Echo
Foot Exam	