NUVIA HEALTH

HEALTH HISTORY FORM

Full Name: **Date of Birth:** **Today's Date:**

Allergies (medications, food, environmental, etc.):

Family & Personal Health History

Check all conditions that apply to you or your immediate family members.

Condition	Self	Mom	Dad	Sister	Brother	GM	GF
Alcohol/Drug Abuse							
Anemia							
Anxiety							
Arthritis							
Asthma							
Bipolar Disorder							
Cancer (Type:____)							
Cataracts							
Chronic Bronchitis							
Crohn's Disease							
Depression							
Diabetes — Type 1							
Diabetes — Type 2							
Emphysema/COPD							
Endometriosis							
Esophageal Reflux/GERD							
Hearing Problems							
Heart Attack							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Irritable Bowel Syndrome							
Kidney Disease							
Leukemia							
Migraine Headaches							
Neurological Disease							

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Condition	Self	Mom	Dad	Sister	Brother	GM	GF
Osteoporosis							
Peptic Ulcer							
Schizophrenia							
Sexually Transmitted Infection							
Stroke							
Thyroid Disease (Hypo/Hyper)							
Tuberculosis							
Ulcerative Colitis							
Other:							

HEALTH HISTORY FORM

Hospitalizations & Surgeries

Hospitalization / Surgery	Reason	Year

Current Medications

Include prescription medications, over-the-counter drugs, vitamins, and supplements.

Medication	Dose	How Often	How Long

Healthcare Screenings

Healthcare Screening / Treatment	Date of Last
Routine Physical Exam	
Routine Eye Exam	
Stool Occult Blood Test	
Electrocardiogram (EKG)	
Cardiac Stress Test	
Sigmoidoscopy	
Colonoscopy	

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Healthcare Screening / Treatment	Date of Last
Bone Density Scan	
Tetanus Injection	
Pneumonia Injection	
TB Skin Test	
Mammogram	
PAP Smear	

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Habits & Lifestyle

Do you use any form of tobacco? ☐ Yes ☐ No

If yes, type and amount: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, type and amount: _____

Do you use recreational drugs or have a history of substance abuse? ☐ Yes ☐ No

If yes, details: _____

Are you sexually active? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

If yes, type and frequency: _____

Do you follow any special diet? ☐ Yes ☐ No

If yes, describe: _____

Female Patients Only

Age Menses Began: _____ Regular Menses: ☐ Yes ☐ No Last Menstrual Period: _____

Last Mammogram: _____ Last PAP: _____ OB/GYN: _____

# of Pregnancies: _____ Live Births: _____ Form of Birth Control: _____

Are you currently pregnant or think you may be pregnant? ☐ Yes ☐ No

I certify that the above information is correct and true to the best of my knowledge. I will not hold my provider or any members of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date