HOSA Medical Office

Health History Form

Date _____

Name _____

Age _____ Date of birth _____ Sex _____

Occupation _____

Patient's Chief Complaint _____

_____

_____

Medications (List all medications you are currently taking.)	**Allergies** (List all allergies)

Patient's Past History:

Do you have or have you ever had the following? Check each box that is answered "yes".

- ☐ Rashes or hives
- ☐ Headaches, dizziness, fainting
- ☐ Blurred vision
- ☐ Hearing loss
- ☐ Sinus trouble
- ☐ Asthma
- ☐ Sore throats
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Night sweats
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Rheumatic fever
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heartburn or indigestion
- ☐ Nausea and/or vomiting
- ☐ Peptic ulcer
- ☐ Rectal bleeding, hemorrhoids
- ☐ Sudden weight gain or loss
- ☐ Kidney disease or stones
- ☐ Painful and/or difficult urination
- ☐ Diabetes
- ☐ Sexually transmitted disease
- ☐ Become tired or upset easily
- ☐ Depression
- ☐ Convulsions
- ☐ Back pain or injury

Please use the space below to explain any "yes" answers.

Serious Illness/Injuries/Hospitalizations	**Date**	**Outcome**

Patient's Family and Social History:

	Yes	No	Quantity/Frequency
Do you use tobacco?	◯	◯	_____
Do you use drugs?	◯	◯	_____
Do you use alcohol?	◯	◯	_____
Do you exercise regularly?	◯	◯	_____

Relation	**Age**	**State of Health**	**Serious Illness and/or Cause of Death**
Father			
Mother			
Brother			
Sister			