STATERA
Integrated Health & Wellness Solutions

Health History Form

Todays Date:_____

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Personal Info: Name_____DOB_____ SSN _____ Sex M / F

Address_____ City_____ State_____ Zip _____

E-mail _____ Phone_____

Other Providers: _____

Medical History

▫ ADD/ADHD	▫ Abuse/Domestic Violence	▫ Acid Reflux (GERD)	▫ Allergies (Food, Environmental)
▫ Allergies/Hayfever	▫ Anxiety Disorder	▫ Arthritis	▫ Asthma
▫ Autoimmune Disease	▫ Birth Defects	▫ Bleeding Disorder	▫ Blood Disease
▫ Brain Injury	▫ Breast Cancer	▫ COPD	▫ Cancer
▫ Congestive Heart Failure	▫ Coronary Artery Disease	▫ Depression	▫ Dermatologic Disorder
▫ Diabetes	▫ Diverticulitis	▫ Ear/Hearing Problems	▫ Fibromyalgia
▫ Gout	▫ Head Trauma/Injury	▫ Heart Attack (MI)	▫ Heart Problems
▫ Hepatitis/Liver Disease	▫ High Cholesterol	▫ History of STDs	▫ History of abnormal pap
▫ Hypertension	▫ Kidney Disease	▫ Lung Disease	▫ Lyme disease
▫ Multiple Sclerosis	▫ Muscle/Joint/Bone problems	▫ Neurologic Issues	▫ Osteoporosis
▫ Parkinson's Disease	▫ Peripheral Vascular Disease	▫ Polycystic Ovary Syndrome	▫ Rheumatoid Arthritis
▫ Seizures/Epilepsy	▫ Serious Illness or Injuries	▫ Skin Problems	▫ Stroke
▫ Thyroid Problems	▫ Dizziness/Vertigo	▫ Other	

Medications

List all current medications. Include prescribed and over-the-counter drugs such as vitamins and inhalers.

Medication	Dosage	Frequency

Allergies

List all known allergies.

Allergy	Reaction(s)	Date of first reaction (approx.)	Not current

Surgical History

Check all surgeries that apply, and add year please.

▫ Adenoid Surgery	▫ Angioplasty	▫ Appendectomy	▫ Arthroscopic Surgery
▫ Colonoscopy	▫ Ear Tube	▫ Gyn Surgery	▫ Hernia Repair
▫ Orthopedic Surgery	▫ Back Surgery	▫ Breast Surgery	▫ CABG
▫ Cancer Surgery	▫ Carpal Tunnel	▫ Cholecystectomy	▫ Sinus Surgery
▫ Thyroid Surgery	▫ Tonsillectomy	▫ Total Hysterectomy	▫ Tubal Ligation
▫ Vasectomy	▫ Any other Surgical History		

GYN History

Most recent: Mammogram_____ Bone Density (DEXA)_____

Date of last Pap Smear _____ Abnormal Pap in past: Yes/No. Type if known_____

Last Menstrual Period_____ Duration _____

Age at first child (if any)_____ Age when Period first occurred _____

HPV Vaccine Yes/No History of STD/STI Yes/No

Current Birth Control Method _____

Family History

Check all that apply.

Disease/Condition	Family member(s)	Disease/Condition	Family member(s)
▫ Stroke		▫ Cancer	
▫ COPD/Emphysema		▫ Breast Cancer	
▫ Alzheimer's Disease		▫ Colon Cancer	
▫ Anxiety/Panic Attacks		▫ Mental Illness	
▫ Arthritis		▫ Multiple Sclerosis	
▫ Asthma		▫ Heart Failure	
▫ ADHD		▫ Osteoarthritis	
▫ Heart Attack		▫ Osteoporosis	
▫ Depression		▫ Pulmonary Embolism	
▫ Diabetes Mellitus		▫ Rheumatoid Arthritis	
▫ High Cholesterol		▫ Seizure	
▫ High Blood Pressure		▫ Other	

Immunizations

Check all the vaccinations that you have received

Vaccination	Date received (approx.)	Vaccination	Date received (approx.)
▫ Tetanus		▫ HPV/Gardasil	
▫ Hep B		▫ Flu Shot	
▫ Meningitis		▫ Typhoid	
▫ Chicken Pox		▫ Shingles	

Social History

Smoker(circle one): Never Former Current Packs per day_____ Years of use _____ Quit year_____
Passive smoke exposure? Yes / No
Chewing Tobacco (circle one): None 1/day 2-4/day 5+/day
Alcohol Drinks per week (circle one): None Occasional Moderate Heavy Drinks/Day_____ Years of use_____
Illicit drugs? Yes/No if yes, which? _____

Caffeine servings per day (circle one): None Occasional Moderate Heavy Drinks/Day_____
Type of diet (circle one) Regular Vegetarian Vegan Gluten-Free
Diabetic Low Carb Cardiac Specific _____

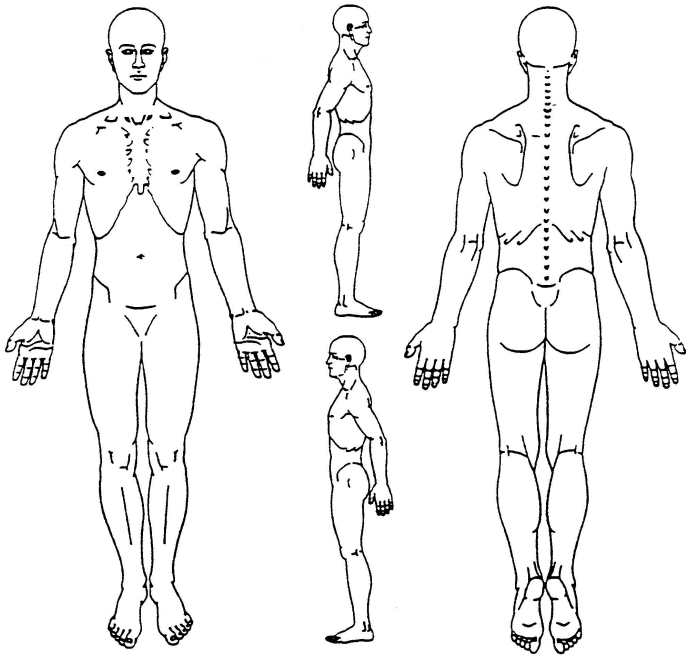
Exercise type and frequency per week: _____Hobbies/Activities _____
Are you currently employed? Yes / No Occupation_____ If yes, where? _____
Highest grade completed: _____
Marital Status (circle one): Child < 18 Single Married Divorced Separated Widowed Domestic Partner
Number of Siblings? _____ Number of Children?_____

Are you a spiritual person? Yes / No
Please identify what religion (if any) you belong to _____
Do you have any social or cultural beliefs or circumstances that you would like the provider to know? Yes / No
If yes, please explain: _____
Please list your main support systems: _____
Sexual Orientation _____

Have you recently suffered any significant losses or trauma? Yes / No
If yes, please explain: _____

Pain

Indicate on the figure below where you are experiencing pain (if any)



Pain Quality
Ache: ///////
Stabbing: *****
Burning: +++++
Numbness: |||||||
Pins & Needles: xxxx