Health History: The Roxbury Institute

Patient Name _____ Date of Birth _____

Drug Allergies: _____

Past Medical History: Have you ever had any of the following

Aids/HIV	Yes	No	Easy Bleeding/Bruising	Yes	No	Kidney Disease	Yes	No
Anemia	Yes	No	GI/Bowel Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Heart Disease/Attack	Yes	No	Stomach Ulcer	Yes	No
Breast Disease	Yes	No	Hepatitis	Yes	No	Stroke	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Diabetes	Yes	No	High Cholesterol	Yes	No	Tuberculosis	Yes	No

List any other major illnesses: _____

List all surgeries and dates: _____

List any medications you are taking, including non-prescription drugs, vitamins, and herbs:

_____

Circle if you have a Pacemaker/AICID, Prosthesis, Artificial Heart Valve, or Joint Replacement

Have you ever had Skin Cancer? (If yes, list type, date, and location):

_____

Review of Systems: Circle any of the following you have had in the past year

blood in urine	Chronic pain	Irregular heartbeat	Seizures
Blurry vision	Depression	Jaundice	Severe sunburns
Chest pain	Dry eyes	Joint pain	Swollen feet/ankles
Chronic cough	Easy bruising/bleeding	Migraines	Weight gain/loss
Chronic diarrhea	Heartburn	Mouth sores	Yeast infection

Family History: Has any blood relatives ever had the following

Breast Cancer	Yes	No	Heart disease	Yes	No	Melanoma	Yes	No
Depression	Yes	No	High blood pressure	Yes	No	Skin cancer	Yes	No
Diabetes	Yes	No	Kidney disease	Yes	No	Stroke	Yes	No

Social History:

Do you use tobacco? (Type & Amount Per Day) _____ Date Quit: ____
Do you drink alcohol? (Type & Amount Per Week) _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

X_____

Signature of patient or parent if a minor Date