Penn Highlands Healthcare

Name: DOB: Today's Date:

PAST MEDICAL HISTORY: **Have you or your family EVER been diagnosed as having any of the following:** (circle all that apply)

Cancer	SELF	FAMILY MEMBER	Heart Problems	SELF	FAMILY MEMBER
Asthma	SELF	FAMILY MEMBER	High Blood Pressure	SELF	FAMILY MEMBER
Emphysema/COPD	SELF	FAMILY MEMBER	Depression	SELF	FAMILY MEMBER
Hepatitis	SELF	FAMILY MEMBER	Stroke	SELF	FAMILY MEMBER
Anemia	SELF	FAMILY MEMBER	Multiple Sclerosis	SELF	FAMILY MEMBER
Tuberculosis	SELF	FAMILY MEMBER	Diabetes	SELF	FAMILY MEMBER
Chemical Dependency	SELF	FAMILY MEMBER	Kidney Disease	SELF	FAMILY MEMBER
Osteoporosis	SELF	FAMILY MEMBER	Thyroid Problems	SELF	FAMILY MEMBER
Rheumatoid Arthritis	SELF	FAMILY MEMBER	Epilepsy	SELF	FAMILY MEMBER
Other Arthritis Conditions	SELF	FAMILY MEMBER	Other Medical Conditions		
Blood Clots	SELF	FAMILY MEMBER			

Have you fallen in the past year?_____YES _____NO If so, how many times?_____

SURGICAL HISTORY:

_____

_____

_____

_____

MEDICATIONS: Please list any medications you are currently taking, including vitamins and herbal supplements:

Medication	Dosage/Frequency	Reason for Medication	Date Medication Started	Who Prescribed Medication?

HAVE YOU EVER TAKEN ANY TYPE OF ANTI-INFLAMMATORY MEDICATION?_____YES _____NO

If YES, Please list the medication, when taken, why taken, and any complications or side-effects: _____

ALLERGIES:

Please list any medications you are allergic to:

Are you allergic to LATEX?_____YES _____NO

IMMUNIZATIONS:

Have you had a flu vaccine this year? _____YES_____NO_____WHEN

Have you had a pneumonia vaccine? _____YES_____NO_____WHEN

SOCIAL HISTORY:

Do You...	YES	NO	What type:	How Much?	If quit, when?
Use tobacco in any form?					
Drink alcohol?					
Have a history of substance abuse?					
Drink Caffeine?					
Are You Pregnant?					
Do you feel depressed or hopeless?					