North San Antonio Healthcare Associates
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(210) 822-3646

Confidential Self-Administered Health History **Date:** _____

Patient Name: _____ DOB: ____/____/_____ Age: _____
Address: _____ Marital Status: _____
City, State & Zip: _____ Spouse's Name: _____
Are you employed outside the home? ____Y ____ N Emergency Contact: _____
Employer: _____ Phone #: _____
May we contact you at work? _____Y _____ N Children (ages): _____
Phone: HM (___) _____ W (___) _____ Allergies: _____

Do you have an ADVANCE DIRECTIVE? YES / NO
Would you like information on ADVANCE DIRECTIVES? YES / NO

Past Medical History: If you have had any illness or disease listed below, please place a checkmark next to the illness. Write in the dates of the problem or the date the diagnosis was made. If you have been hospitalized for the condition, write "H" in parenthesis (H) after the date.

Childhood illnesses	**Date/Age**
Chicken Pox	
Measles	
Rubella (German Measles)	
Fever Convulsions	
Anemia	
Rheumatic Fever	
Birth Defects	
Other	

Surgery (operations, type and date)	**Date/Age**
Skin	
Eye/Cataract	
Ear/Mastoid	
Tonsil/Adenoid	
Chest/Heart	
Cardiac/Cath	
Ulcer/Stomach	
Gall Bladder	
Intestine/Colon	
Appendix	
Hysterectomy/D&C	
Prostate	
Hernia (what type)	
Bladder/Kidney	
Bone/Joint (which joint)	
Back/Neck/Disk	
Other	
Other	

Allergies to medication, food, or other factors
Describe your reaction S (skin), H (hay fever), A (asthma)

For Women Only
Age you started your menstrual periods:
When was your last pap test:
Has your pap smear ever been abnormal:
Have your periods stopped: Age:
How many times have you been pregnant?

Adult illnesses	**Date/Age**
Diabetes	
High Blood Pressure	
Heart Attack or Angina	
Heart Failure	
Stroke	
Chronic Bronchitis or Emphysema	
Pneumonia	
Asthma	
Tuberculosis (TB)	
Thyroid Problem	
Anemia	
Bladder/Kidney Infection (recurrent)	
Kidney Stones	
Prostate Disorders	
Migraine or Severe Headaches	
Seizures/Convulsions	
Muscle Disorder	
Emotional/Psychiatric Problem	
Other Neurologic Disorder	
Ulcer Disease	
Gall Bladder Problem	
Pancreas Disorder	
Liver Disorder/Hepatitis	
Arthritis (Type)	
Back Problem	
Phlebitis (Blood Clots)	
Venereal Disease (VD/STD)	
Skin Disease	
Vertigo	
Glaucoma	
Bleeding Disorder	
Cancer	
Other	
Other	
Other	
Other	
Other	
Other	

Medications

List medications you take regularly, now including "over the counter medications" Specify the name, dosage and frequency if you know them.

Over the counter medications Current/Past

Prescription medications Current/Past

Life Habits

Did you ever smoke/do you smoke now?___Y ___ N
If yes, how long and how much? _____
Cigarettes, Cigar, Pipe? _____
Do you drink alcohol? ___Y___N Drinks/week? ___
Do you feel that you drink too much? _____
Do you use recreational drugs? _____
Sexual Orientation? _____

Today's Problems

Please tell us you current symptoms or problems, If any, that are bothering you today. _____

Immunizations	**Date**
Tetanus	
Flu	
Pneumonia	
Other	
Other	

Place an "X" in the appropriate box:

	Asthma	Alcoholism	Cancer	High Cholesterol	Diabetes	Glaucoma	Gout	Heart Attack / Heart Disease	High Blood Pressure	Thyroid Disease	TB	Deceased at Age?
Father												
Mother												
Father's Father												
Father's Mother												
Mother's Father												
Mother's Mother												
Brothers												
Sisters												
Children												

Other MD's

OB/GYN: _____ Cardiology: _____ Surgeon: _____

GI: _____ Urology: _____ Orthopedic: _____

Podiatry: _____ Other: _____ Other: _____

To the best of my ability, the answers I have given on this Health History are true.

Signature_____