Cigarroa CLINIC

Health History Intake Form

Please take the time to fill out this form as completely as possible. This will help us get a comprehensive health history and expedite your clinic evaluation time.

Form completed by (if other than patient): _____

Patient Name: _____ Date: _____

MEDICAL AND PREVENTATIVE HEALTH

Name of Primary Care Physician: _____

Name of Specialist(s) that you see: _____

_____

Reason for your visit today: _____

_____

Date of Last Exam or Procedure

If not applicable, please leave blank

	Date
Complete Physical	
EKG	
Eye Exam	
Bone Density Exam	
For Men: Prostate Exam	
For Women: PAP Smear	
Colonoscopy	
Mammogram	

	Date
Tetanus Vaccine	
Flu Vaccine	
COVID Vaccine	
Shingles Vaccine	
Pneumococcal Vaccine	
Tuberculosis skin test and Reaction	
Pneumococcal Vaccine	

ALLERGIES: List medication(s) or foods you are allergic to and what reaction(s) you have

_____

_____

_____

CURRENT MEDICATIONS: **List all medications**, including over-the-counter and homeopathic/ natural remedies, **with dosages and times taken**. *Please note that bringing your medications to the clinic is preferred. If you have your medications with you, you may skip this section or include only the ones that are not present with you today.*

Medication	Dose	Times per day

LIST ALL HOSPITALIZATIONS, SURGERIES AND SERIOUS ACCIDENTS. Include year and place treated.

_____

_____

_____

_____

_____

_____

SOCIAL/DIETARY HABITS

How many meals do you eat each day? _____ When is your largest meal? _____
Do you eat a special diet? (specify) _____
How much coffee/tea do you drink each day? _____
Any change in appetite? _____Usual Weight? _____
Have you ever smoked? _____ How much do you smoke? _____
How long have you smoked? _____ What age did you begin smoking? _____
Have you ever considered quitting? _____ Do you drink alcohol? _____
How often? ☐ Socially ☐ Daily ☐ Rarely ☐ Other:_____
Do you use marijuana or any other recreational drug? ☐ Yes ☐ No
If yes, how often? ☐ Socially ☐ Daily ☐ Rarely ☐ Other:_____
Are you sexually active? ☐ Yes ☐ No If so, do you use protection? _____

FAMILY HEALTH HISTORY

Relation	Age if Living	Age at Death	Major Health Problems	Cause of Death
FATHER				
MOTHER				
PATERNAL GRANDPARENTS				
MATERNAL GRANDPARENTS				
SIBLINGS				

GYNECOLOGICAL HISTORY

Menopause: Age _____ Breast self exam? _____Yes _____No
# of pregnancies _____ # of live births _____
Last Menstrual period: _____ Heavy or normal periods? _____
Regular or Irregular periods? If irregular, please elaborate: _____
_____
Birth control methods? _____
Pregnancy complications? If so, please elaborate: _____
_____

PAST MEDICAL HISTORY

Please check the appropriate boxes below if you have ever been diagnosed with any of the following:

☐ Pneumonia	☐ Diabetes	☐ Anemia	☐ Asthma/emphysema
☐ Bronchitis	☐ Heart Attack	☐ Hepatitis	☐ Irregular heart rhythm
☐ Cancer	☐ ADD/ADHD	☐ Thyroid disease	☐ High blood pressure
☐ Stomach/intestinal ulcers	☐ Alcoholism	☐ Gout	☐ Kidney failure
☐ Kidney stones	☐ Seizures	☐ Strokes	☐ Arthritis
☐ Anxiety	☐ Cataracts	☐ Glaucoma	☐ Parkinson's disease
☐ Blood clots/phlebitis	☐ High cholesterol	☐ Pancreatitis	☐ Migraine headaches
☐ Hernias	☐ Diverticulosis	☐ Sexually transmitted diseases	
☐ Back Pain	☐ Bipolar Disorder	☐ Heart Failure	☐ Cardiovascular Disease (Carotid, peripheral, coronary)
☐ Depression	☐ Gall stones	☐ Pacemaker	☐ Obstructive Sleep Apnea
☐ Osteoporosis	☐ Rheumatism	☐ Incontinence	☐ Insomnia

If any boxes were checked off, please describe below anything pertaining to your medical history that you feel we should know:

_____

_____

_____

_____