Ryan Medical Associates, P.C.

Health History

Name _____ Age _____ Birthdate _____ Today's Date _____

Currently Live: ☐ Alone ☐ With Family ☐ With Friends ☐ With Significant Other

Marital Status: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Widowed

Check all items either Yes or No & give approximate date if past	No	Yes Now	Yes Past	Date	Check all items either Yes or No & give approximate date if past	No	Yes Now	Yes Past	Date
Abnormal electrocardiogram (EKG)					Heart murmur as an adult				
Alcoholism					Hemorrhoids, rectal problems				
Anemia (Type)					Hepatitis (Type)				
Angina / chest pain					Hernia				
Arteriosclerosis					High blood pressure				
Arthritis					High cholesterol				
Asthma / Hay fever					HIV / AIDS				
Blood disease					Jaundice				
Broken bones					Kidney or bladder disease				
Cataracts					Kidney stones				
Chemical dependency					Low blood pressure				
Chemotherapy					Migraine headaches				
Chronic bronchitis / emphysema					Mitral valve prolapse				
Chronic liver disease					Night sweats				
Colon, bowel trouble-diverticulitis/colitis					Phlebitis				
Convulsions, seizures					Poor blood clotting				
Deafness or ringing ears					Psychiatric care				
Diabetes					Rheumatic fever				
Ear infections					Sexually transmitted/venereal disease				
Enlarged heart					Shortness of breath				
Epilepsy / seizures					Sinus trouble				
Forgetfulness					Skin disease / psoriasis / eczema				
Glaucoma					Stroke				
Gall stones					Thyroid problem				
Gout					Tuberculosis or positive T.B. test				
Head injury					Wakefulness, difficulty sleeping				
Heart attack					Weight loss or weight gain				

Habits

Do You	Yes	No	Daily Consumption
Smoke	☐	☐	_____ Pkgs
Drink Coffee . .	☐	☐	_____ Cups
Drink Alcohol . .	☐	☐	_____ oz.
Drink Beer. . . .	☐	☐	_____ oz
Chew Tobacco .	☐	☐	_____
Use Drugs	☐	☐	

Type _____

Frequency _____

Medications

Please list all medication you are now taking, including those you buy without a doctor's prescription.

_____

_____

_____

Allergies

List anything that you are allergic to, such as medications, foods, etc, and indicate how each affects you.

_____

_____

_____

Immunizations: ☐ Tetanus-date:_____ ☐ Flu-date _____ ☐ German Measles-date_____ ☐ Pneumonia-date_____

Over