SUMMA HEALTH CARE

Health History Form

Name: _____

DOB: _____

Please fill out this form completely and to the best of your knowledge:

Date it Started	Chronic Medical Problem List	Past Surgical History	Date

		Hospitalizations	Date

Family History of:

Y	N	Family Member
☐	☐	**Alzheimer's Dz** _____
☐	☐	**Breast CA** _____
☐	☐	**CAD** _____
☐	☐	**CVA Dz** _____
☐	☐	**Colon CA** _____
☐	☐	**Depression** _____
☐	☐	**DM** _____
☐	☐	**Diabetes** _____
☐	☐	**Glaucoma** _____
☐	☐	**Hypercholesterolemia**_____
☐	☐	**HTN** _____
☐	☐	**Ovarian CA** _____
☐	☐	**Prostate CA** _____
☐	☐	**Skin CA** _____
☐	☐	**Thyroid Dz** _____
☐	☐	**Autoimmune Dz** _____
☐	☐	**Iron Deficiency** _____

Initial Risk Assessment:

Please pick any that apply to you

Date if known

☐ Alcohol/Drug use _____

☐ STDs _____

☐ HIV/AIDs _____

☐ Domestic Violence _____

☐ Osteoporosis _____

☐ Geriatric Assessment _____

☐ MMSE _____

☐ Autoimmune: _____ _____

☐Other: _____ _____

Educ: ☐ JHS ☐ HS ☐ College

☐ GED ☐ Other _____

Signature: _____ Date: _____