Family Health Care of Northwest Ohio, Inc.
1052 S. Washington Street
Van Wert, OH 45891
Phone: 419-238-6747 Fax: 419-238-3721

Health History

It is important for us to have a complete medical history so that our health care team can give you the most appropriate care possible. Please answer all of the following questions related to your medical history

Name_____ DOB_____ Today's Date_____

PERSONAL HISTORY - Please check all that apply: **FAMILY HISTORY**
(if yes, please include diagnosis) Mother Father

Tobacco Use (type/amount) _____	_____	_____
Alcohol (type/amount) _____	_____	_____
Recreational Drugs (type) _____	_____	_____

	Personal	Mother	Father
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
Heart Attack	☐	☐	☐
Heart Disease	☐	☐	☐
Poor Circulation	☐	☐	☐
Stroke	☐	☐	☐
Emphysema	☐	☐	☐
Asthma	☐	☐	☐
COPD	☐	☐	☐
Breathing Problems	☐	☐	☐

Specify if not listed above_____

	Personal	Mother	Father
Liver Disorder	☐	☐	☐
Hepatitis	☐	☐	☐
Seizure Disorder	☐	☐	☐
Bleeding Disorder	☐	☐	☐
Kidney/Bladder Problems	☐	☐	☐
Depression	☐	☐	☐
Cancer	☐	☐	☐
(cancer type)_____			
Bowel problem_____	☐	☐	☐
Skin Problem_____	☐	☐	☐
Other _____	☐	☐	☐

When was your last full physical exam _____

Have you ever been hospitalized?_____Where_____Reason_____

_____

Please list all surgeries and procedures (include date when possible)_____

_____

Please list all medications you are currently taking:

Name	**Dosage**	**Frequency**

(Please include any over the counter medications/vitamins - Continue on the back if needed)

.....Continued on other side.....

Medication allergies? if Yes, please list below

Environmental allergies?

Pharmacy currently using: _____

Have you ever had a colonoscopy? ___NO___YES (- if yes, date & location)_____

FEMALES: Date of last menstruation_____Mammogram date_____

Pap Smear date & location_____

Number of Pregnancies_____Live Births_____

MALES: Date of last prostate exam_____

Do you have a living will/Advanced Directive? ___NO ___YES

Do you have any impairments/communication needs? ___NO ____YES – if yes, please list: _____
(blindness, hearing loss, etc.)

MEDICATIONS CONTINUED (if needed)

Medication Name	Dosage	Frequency