ValleyHealth
Berkeley Family Medicine

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Health History

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Current Medical Problems

Problem	Year Diagnosed

Medications

☐ None Taken or ☐ See attached List *(or list below)*

Name	Dosage	Frequency *(i.e. once or twice daily)*

Allergies

Drug/Food	Reaction

Surgery History

Surgery	Year

Social History

Tobacco Use
Any cigarette use?
of cigarettes daily:
of years of use:
Any chewing tobacco use?
Amount use daily:
of years of use:

Alcohol Use
Type of alcohol:
of drinks weekly:
of years of use:

Drug Use
Any illicit drug use?
IV drug use?
What types?
How long?

Family History

Relation	Diagnosis	Age of Diagnosis

Immunization History

Immunization	Yes/No	Year
Flu shot		
Gardasil		
Pneumovax 23		
Prevnar 13		
Tetatus or Tdap		
Zostavax (shingles shot)		

FEMALES ONLY

Last mammogram:	Any abnormal?
Last pap:	Any abnormal?
Do you still have your uterus/ovaries?	
Are you still having regular periods?	
Last menstrual period:	
Last DEXA (bone density screening for osteoporosis):	
Are you using any form of birth control?	

MALES ONLY

Last PSA:

BOTH Females and Males

If born between 1945-1965, have you had Hepatitis C screening?	
Last colonoscopy:	Any abnormalities?
When were your last screening labs done (blood sugar, cholesterol)?	