Personal & Family Medical History

Aloha Malama Health

Name: _____ Today's Date: _____

Allergies (incl. food, medications, environmental) and reactions: _____

Ethnicity: _____ Social History: Children? Ages_____

Do you, or have you ever smoked cigarettes? Yes ___ No ___ How many ppd: _____ Years smoked: _____ Quit date: _____

Alcohol: Do you or have you ever consumed alcohol? Yes ___ No ___ How many drinks/week (average): _____

Illicit/illegal drug use? Yes ___ No ___ Substance used: _____ Still using? Yes ____ No _____ Quit date: _____

Current & Past Medical History (you and your family): Please specify personal or family history on line provided, using the following codes: Sister (S), Brother (B), Mother (M), Father (F), Mat uncle (MU), Mat aunt (MA), Pat uncle (PU), Pat aunt (PA), Maternal Grandmother (MGM), Paternal grandmother (PGM), Maternal Grandfather (MGF), Paternal Grandfather (PGF)

Self	Family	Condition
		Heart Disease (CAD)
		Heart Attack (MI)
		Irregular heartbeat
		Peripheral vascular disease
		Hypertension
		Elevated cholesterol
		Blood clots
		Anemia
		COPD (emphysema, bronchitis)
		Asthma
		Liver Disease (hepatitis)
		Alcoholism
		Kidney disease
		Recurrent UTIs
		Pancreatitis
		Vision problems
		Cancer (type)
		Thyroid disease
		Diabetes (type)
		Gallbladder problems
		GERD

		Ulcers (where)
		Varicose veins
		Diverticulosis/diverticulitis
		Crohn's disease/IBS
		Bleeding/clotting disorder
		Hormonal problems (PCOS, ED, Low Testosterone, other)
		Osteoarthritis
		Rheumatoid arthritis
		Degenerative disc disease
		Osteoporosis
		Fractures
		Migraines
		Insomnia
		Stroke (CVA)
		Anxiety
		Depression
		ADD/ADHD
		Bipolar d/o
		Schizophrenia
		Other mental illnesses Bipolar/Schizophrenia/other

		Other conditions:

Please list any surgeries or procedures	Approximate date(s)

Medication Name & Dosage	How often do you take this medication?	Who prescribed this medication for you?

*Please share anything else you would like to share with me about your health (if any):

_____
_____
_____
_____

I certify that all the information included on this form is accurate and correct to the best of my knowledge. I understand that by omitting anything or falsifying information on this form could be detrimental to my treatment and health.

Print Name: _____ Signature: _____ Date: _____