History of My Health

Name	Sex Male Female Date of birth / / (age:)
Address	Health insurance Insurance policy number

1 Past medical history (Please check all that apply.)

heart disease (angina / myocardial infarction / arrythmia / heart failure / other:) / hypertension / renal failure / diabetes / stroke (cerebral infarction / cerebral hemorrhage) / cancer (details:) / asthma / seizure / rheumatoid arthritis / depression/ other:

2 Family medical history (Please check all that apply.)

heart disease (angina / myocardial infarction / arrythmia / heart failure / other:) / hypertension / renal failure / diabetes / stroke (cerebral infarction / cerebral hemorrhage) / cancer (details:) / asthma / seizure / rheumatoid arthritis / depression/ other:

3 Surgical history

Age	Reason for operation	Age	Reason for operation

4 Drug allergy

① Name of the drug What happened?	② Name of the drug What happened?

5 List of medications: medications in current use

(Please write all the medications you take including pill, inhalation, patch, injection drugs.)

Medications	dose	Medications	dose

6 Are there any symptoms bothering you today?

Seven questions to think about before you see your doctors

These questions are helpful to explain your problems to your doctors.
Please answer these questions and bring them with the "History of My Health" form.

1 Why did you come to see the doctor today?

2 What is bothering you the most?

3 When did the symptom start?

4 What makes the symptom worse?

5 What makes the symptom better?

6 Have you ever seen other doctors about this symptom before?

7 Do you have a preference for what you want the doctor to do today?