

# HOSA Medical Office Health History Form

Date \_\_\_\_\_

Name \_\_\_\_\_  
 Age \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex \_\_\_\_\_  
 Occupation \_\_\_\_\_

**Patient's Chief Complaint** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medications (List all medications you are currently taking.)	Allergies (List all allergies)

## Patient's Past History:

Do you have or have you ever had the following? Check each box that is answered "yes".

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Rashes or hives                | <input type="checkbox"/> Tuberculosis                 | <input type="checkbox"/> Sudden weight gain or loss         |
| <input type="checkbox"/> Headaches, dizziness, fainting | <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Kidney disease or stones           |
| <input type="checkbox"/> Blurred vision                 | <input type="checkbox"/> Rheumatic fever              | <input type="checkbox"/> Painful and/or difficult urination |
| <input type="checkbox"/> Hearing loss                   | <input type="checkbox"/> Chest pain                   | <input type="checkbox"/> Diabetes                           |
| <input type="checkbox"/> Sinus trouble                  | <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Sexually transmitted disease       |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Heartburn or indigestion     | <input type="checkbox"/> Become tired or upset easily       |
| <input type="checkbox"/> Sore throats                   | <input type="checkbox"/> Nausea and/or vomiting       | <input type="checkbox"/> Depression                         |
| <input type="checkbox"/> Shortness of breath            | <input type="checkbox"/> Peptic ulcer                 | <input type="checkbox"/> Convulsions                        |
| <input type="checkbox"/> Persistent cough               | <input type="checkbox"/> Rectal bleeding, hemorrhoids | <input type="checkbox"/> Back pain or injury                |
| <input type="checkbox"/> Night sweats                   |   |   |

*\*Please use the space below to explain any "yes" answers.*

Serious Illness/Injuries/Hospitalizations	Date	Outcome

## Patient's Family and Social History:

	Yes	No	Quantity/Frequency
Do you use tobacco?	( )	( )	_____
Do you use drugs?	( )	( )	_____
Do you use alcohol?	( )	( )	_____
Do you exercise regularly?	( )	( )	_____

Relation	Age	State of Health	Serious Illness and/or Cause of Death
Father			
Mother			
Brother			
Sister			