Anthony A. Natelli, M.D.

Health History Form

Name: ____________________________ Date of Birth: ____________ Occupation: _______________________ Today's Date: _____________

PAST MEDICAL HISTORY

Self	Family	
____	____	Asthma
____	____	Headaches
____	____	Heart Problems
____	____	High Cholesterol
____	____	Diabetes
____	____	Cancer Type
____	____	Hypertension
____	____	Hepatitis
____	____	Stroke
____	____	Depression
____	____	Back Problems
____	____	Kidney / Bladder
____	____	Recent Weight Loss

MEDICATIONS

Drug	Dose	How Often
_____________________	___________________	_____________________________
_____________________	___________________	_____________________________
_____________________	___________________	_____________________________
_____________________	___________________	_____________________________
_____________________	___________________	_____________________________

Alcohol Use No ____ Yes ____ If yes, frequency of use _______________________

Tobacco Use No ____ Yes ____ If yes, frequency of use _______________________

Coffee / Tea No ____ Yes ____ If yes, amount ______________________________

Street Drugs No ____ Yes ____ If yes, type _________________________________

Known allergies and reactions: ____

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IMMUNIZATIONS	YEAR
____ MMR	__________
____ Tetanus	__________
____ Hepatitis	__________
____ Pneumovax	__________
____ Flu Vaccine	__________

HOSPITALIZATIONS / SURGERIES

DATE	REASON
___________	____
___________	____
___________	____
___________	____

Do you have any other medical problems for which you have been seeing a doctor? Please list them:

1)____________________________________ ; 2)____________________________________ ; 3)____________________________________

Are you having any symptoms that you would like to discuss? Please list them:

1)____________________________________ ; 2)____________________________________; 3)____________________________________

For Women Only

Date of last menst period: ______________

Birth Control: No ____ Yes ____ If yes, type used __________________

Breast Exam: Normal / Abnormal

Number of Pregnancies

Births ____ Miscarriages ____ Abortions ____

PAP Test: Normal / Abnormal

Mammogram: Normal / Abnormal