ELLENBECKER PERSONALIZED MEDICINE

Modern Care, Intentional Focus

COMPREHENSIVE HEALTH HISTORY

Please complete this form as thoroughly as possible prior to your first visit. This information helps us provide truly personalized care. If a section does not apply, please write "N/A."

PATIENT INFORMATION

Full Name: _____ **Date of Birth:** _____

Preferred Name: _____ **Sex Assigned at Birth:** _____

Today's Date: _____ **Occupation:** _____

Primary Pharmacy (name & location): _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone: _____

SURGICAL HISTORY

List all prior surgeries or procedures, with approximate year.

Procedure	Year	Surgeon / Hospital (if known)

HOSPITALIZATIONS

Include hospitalizations not already listed above (e.g., for illness, injury, or childbirth).

Reason for Hospitalization	Year	Hospital (if known)

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CURRENT MEDICATIONS

Please list all prescription medications you currently take, including dose and frequency.

Medication	Dose	Frequency	Prescribing Provider

SUPPLEMENTS & OVER-THE-COUNTER PRODUCTS

Include vitamins, herbal products, and OTC medications taken regularly.

Supplement / OTC Product	Dose	Frequency

ALLERGIES

Include medication, food, and environmental allergies, and the reaction they cause.

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Allergen	Reaction

PAST MEDICAL HISTORY / DIAGNOSES

Please check any conditions you have been diagnosed with, and list the approximate year if known.

☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Thyroid Disease

☐ Heart Disease ☐ Asthma / COPD ☐ Cancer (type below) ☐ Autoimmune Disease

☐ Kidney Disease ☐ Liver Disease ☐ Depression / Anxiety ☐ GERD / Reflux

☐ Sleep Apnea ☐ Osteoporosis ☐ Arthritis ☐ Other (list below)

Please list any conditions checked above (with year of diagnosis) and any not listed:

Condition	Year Diagnosed	Notes

FAMILY HISTORY

Please note health conditions affecting your immediate family members, with particular attention to cancer, diabetes, heart disease, and any known genetic or hereditary conditions.

Relation	Living? Age / Age at Death	Cancer (type)	Diabetes	Heart Disease	Other Conditions
Father					
Mother					
Paternal GF					

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Relation	Living? Age / Age at Death	Cancer (type)	Diabetes	Heart Disease	Other Conditions
Paternal GM					
Maternal GF					
Maternal GM					

Known genetic conditions in the family (e.g., BRCA, familial hypercholesterolemia):
_____

_____

SOCIAL HISTORY

Tobacco / Nicotine Use:

☐ Never ☐ Former (quit year: _____) ☐ Current

Type (check all that apply): ☐ Cigarettes ☐ Chew ☐ Vape

If current or former — amount (packs/day, cans/week, etc.) and years used:
_____

Alcohol Use:

☐ None ☐ Occasional ☐ Weekly ☐ Daily

Type & typical amount per week: _____

Recreational / Other Drug Use:

☐ None ☐ Former ☐ Current

If former or current — please describe: _____

Marital / Relationship Status: _____

Hobbies, Sports, & Regular Physical Activity: _____

_____

Typical Sleep (hours/night) & Sleep Quality: _____

Diet (any specific pattern, e.g. vegetarian, low-carb): _____

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IMMUNIZATIONS

Please attach a copy of your immunization record if available.

Immunization record attached? _____

ADDITIONAL INFORMATION

Advance Directive / Medical Power of Attorney on file elsewhere? _____

If yes, name of Power of Attorney / Healthcare Proxy: _____

Is there anything else about your health history you would like us to know?

Patient (or Guardian) Signature: _____ **Date:** _____