Iowa Family Practice

Health History Form

Name:_____ DOB:_____

Allergies	Reactions

Medication Name	Dose and Frequency

Past Medical History: Chronic problems, surgeries

_____
_____
_____
_____

Family History (relative and condition)

_____
_____
_____
_____
_____

Smoke: Y / N if yes how many packs _____ How many years_____

Illicit drugs: Y / N Alcohol use_____ Occupation: _____

If applicable: Last Pap Smear:_____ Last Mammogram:_____ Last Colonoscopy:_____