Patient Health History Form

Keller Family Medical Center

Burleson Health and Wellness

Patient Information

Name	Date of Birth	Age	Sex
Address			
Phone	Email		
Reason for Visit	Emergency Contact		Phone
Last Physical	Ethnic Origin		

Medications & Allergies

Current Pharmacy _____ Mail order pharmacy _____

Medication	Dose	Frequency

*add any further medications at bottom of form

Allergies (or NKA): _____

Vaccinations

Flu	Hepatitis	Pneumonia	Tetanus/TdaP	Shingles	COVID-19	RSV
				Dose #1 Dose #2		

Social History

Tobacco Use: ☐ Never ☐ Former ☐ Current	For current smokers: Packs per day Ready to quit Y N
Drug Use: ☐ No ☐ Yes (type: _____)	Alcohol Use: ☐ None ☐ Occasional ☐ Regular
Exercise: ☐ Rare ☐ Moderate ☐ Regular	Diet: ☐ Balanced ☐ High-fat ☐ High-carb
Occupation:	

Medical History (Check all that apply)

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Asthma ☐ COPD ☐ Stroke

☐ Anxiety ☐ Depression ☐ Cancer ☐ Thyroid Disorder

☐ Other: _____

9/2025

Family History

Indicate relative if known. If more space is needed, please add at the bottom of the form

☐ Heart Disease _____ ☐ Cancer _____ ☐ Diabetes _____

☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____

☐ Other: _____

Preventive Care

Screening	Date	Normal/Abnormal	Notes
Pap			
Mammogram			
Colonoscopy/Cologuard			
Bone Density Scan			

Females Only

Onset of Periods (Age): _____ Birth control? _____

Last Menstrual Period_____ Last PAP:_____ Cycle lasting: _____ days

Pregnancies:	Date:
1.Vaginal or Cesarean	
2.Vaginal or Cesarean	
3.Vaginal or Cesarean	

Additional Health Information

Please provide any additional information

_____
_____
_____
_____
_____
_____
_____

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

9/2025