Patient Name ______________________
Date of Birth ________________________

Health History

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and released only with your written permission.

Have you had?	Yes	No	Have you had?	Yes	No
Headache			Seasonal Allergies / Hay Fever		
Eye Problem			Epilepsy / Seizures		
Ear Problem			Dizziness / Lightheadedness / Fainting		
Nose Problem			Head Injury / Concussion		
Throat Problem			Bone / Joint Injuries		
Thyroid Disorder			Stomach / Intestinal Problems		
Heart Disease			Diabetes		
Heart Palpitations / Heart Murmur			Muscle Problems		
High / Low Blood Pressure			ADD/ADHD		
Anemia			Chicken Pox / Immunization		
Bleeding Disorders: Hemophilia/Other			Mononucleosis		
Hepatitis / Liver Disease			Alcohol Abuse		
Kidney / Bladder Disorders			Drug Abuse		
Pneumonia / Bronchitis			Sexual Assault/Violence		
Tuberculosis			Eating Disorder		
Asthma / Emphysema / COPD			Emotional Problems-Specify:		

Surgeries:

Hospitalizations:

Immunizations:
Tetanus booster ___________________________
Pneumonia shot ___________________________
Shingles (Zostavax) __________________________
Hepatitis B __________________________________
Flu shot ____________________________________

Screening Tests (Year / Result):
Chest X-Ray: ____________________________________
Colonoscopy: ____________________________________
Bone Density (DEXA): ______________________________
PSA Test (men only): _________________________________
Mammogram (women): _________________________________
PAP Test (women): ____________________________________

Medication Allergies: ☐ **NO KNOWN ALLERGIES**

Over the Counter Medications / Herbals / Supplements:

MEDICATIONS:

Drug	Dosage	Times/Day	Reason for Taking

Please complete the other side of this form.

Betsy Salsbury Merrell, M.D., P.L.L.C.
611 5th Avenue West
Hendersonville, NC 28739

Patient Name ______________________
Date of Birth ________________________

Health History

Family History

Family Member	Year Born	Living?	Health Problems

OB / Gyn History (females only)

Menses:	
Date of last menstrual period:	
Age of first menstrual period	
Are your menses irregular?	
Number of days between periods	
Number of days that periods last	
Pregnancy:	
Are you pregnant?	
Date of last pregnancy	
No. of live births	
No. of abortions or miscarriages	
Type of contraception you are using?	

Social History

Do you use tobacco currently?	
Have you ever smoked in the past?	
How many years / year quit?	
Any dietary preferences / restrictions?	
Number of caffeine drinks/day	
Number of alcohol drinks/day	
Have you ever used illegal or intravenous drugs?	
Number of hours of sleep / night	
How many times / week do you exercise?	
Types of exercise?	
Marital Status	
How many children?	
Are you sexually active?	
Occupation	
Highest Grade Level Acheived	
Hobbies	
Pets	

Who referred you to our practice? ____
Are you experiencing any problems today? ____
____
____
____
____
Is there anything else you would like to discuss with the doctor today? ___________________
____
____
____

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