

Patient Health History



Name: _____ Date of Birth: _____ Age: _____
SS #: _____ Today's Date: _____ Sex: Male Height: _____
Female

Primary Care Physician: _____ Phone Number: _____

Referring MD: _____ Phone Number: _____

Other MD's: Name/Specialty _____

Pharmacy Name: _____ Pharmacy Number: _____

Current problem or reason for consultation: _____

Do you feel you need to be linked to our social worker (counseling or financial issues)? Yes
No

PAST MEDICAL HISTORY: *Please check all the boxes that apply*

- | | | | |
|------------------------|--------------------------|-------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | Hepatitis/Liver Disease | <input type="checkbox"/> |
| Anemia/Blood Disorders | <input type="checkbox"/> | Hypercholesterolemia | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> |
| Blood Clots | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Pancreatitis | <input type="checkbox"/> |
| Cataracts | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> |
| Colitis | <input type="checkbox"/> | Sinusitis | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | Thyroid | <input type="checkbox"/> |
| GERD | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | | |

Other: _____

Other: _____

Any unusual childhood infections or illnesses? _____

OPERATIONS: *Please list year, operation and surgeon (if known)*

1. _____
2. _____
3. _____
4. _____
5. _____

ROUTINE CANCER SCREENING TESTS: *List last date (if known)*

Mammogram: _____

Breast Exam: _____

Pap Smear/Pelvic Exam: _____

Stool for Occult Blood: _____

Prostate Exam/PSA: _____

Chest X-Ray: _____

Colonoscopy/Sigmoidoscopy: _____

SOCIAL HISTORY:

Marital Status: _____

Number of Children: _____ Age/Sex of Children: _____

Spouse Name: _____

Spouse Occupation: _____

Patient Occupation: _____

Highest Level of Education: _____

Patient Lives With:	Self	<input type="checkbox"/>	Child	<input type="checkbox"/>
	Spouse	<input type="checkbox"/>	Parent(s)	<input type="checkbox"/>
	Sibling(s)	<input type="checkbox"/>	Friend	<input type="checkbox"/>
			Other	<input type="checkbox"/> _____

City of Residence: _____ Have you completed an advance directive? Yes
 No

Have you completed a living will? Yes
 No

Smoking History

Cigarettes	<input type="checkbox"/>	How Many Years?	_____
Cigars	<input type="checkbox"/>	Number Per Day	_____
Pipe	<input type="checkbox"/>	If Quit, When?	_____

Alcohol History

Beer	<input type="checkbox"/>	How Many Years?	_____
Wine	<input type="checkbox"/>	How Much Per Day/Week/Month?	_____
Liquor	<input type="checkbox"/>	If Quit, When?	_____

Recreational Drug Use Blood Transfusions HIV Testing

Nutritional Supplements: _____

ALLERGIES TO MEDICATIONS: Yes
 No

NAME OF DRUG(S)/TYPE OF REACTION:

MEDICATIONS:

NAME OF DRUG	DOSE (mg or mcg)	HOW MANY TIMES DAILY	HOW LONG (MONTH/YEARS)

Vaccinations: *Please provide date of last vaccination*

Pneumonia: _____ Flu: _____ Shingles: _____

FAMILY HISTORY:

Relative	Age, If Living	Health Problems	If Deceased, Cause
Father			
Mother			
Sis/Bro			
Sis/Bro			
Sis/Bro			
Sis/Bro			
Sis/Bro			

For other relatives such as grandparents, aunts and uncles: Please check all boxes that apply

- | | | | |
|-----------------|--------------------------|---------------|--------------------------|
| Anemia | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Blood Clots | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> |
| Blood Disorders | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |

Approximatley 10% of cancer is hereditary. If you are concerned your family may be at risk, genetic counseling may be appropriate for you.

- Would you like to discuss this with your physician? Yes
- No

REVIEW OF SYSTEMS: Please check all boxes that apply

GENERAL	FEVER <input type="checkbox"/> CHILLS <input type="checkbox"/>	WEIGHT LOSS <input type="checkbox"/> WEIGHT GAIN <input type="checkbox"/>	FATIGUE <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/>
HEAD	HEADACHES <input type="checkbox"/> BLACKOUTS <input type="checkbox"/> SEIZURES <input type="checkbox"/> DIZZINESS <input type="checkbox"/> HEARING LOSS <input type="checkbox"/> EARACHE <input type="checkbox"/> BLEEDING GUMS <input type="checkbox"/>	RINGING IN EARS <input type="checkbox"/> SINUSITIS <input type="checkbox"/> POST NASAL DRIP <input type="checkbox"/> SORE THROAT <input type="checkbox"/> HOARSENESS <input type="checkbox"/> SORE TONGUE <input type="checkbox"/> NOSEBLEEDS <input type="checkbox"/>	TOOTHACHE <input type="checkbox"/> DOUBLE VISION <input type="checkbox"/> BLURRED VISION <input type="checkbox"/> CATARACTS <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> LAST EYE EXAM _____
CHEST	COUGH <input type="checkbox"/> SPUTUM <input type="checkbox"/> COUGHING UP BLOOD <input type="checkbox"/> WHEEZING <input type="checkbox"/> BRONCHITIS <input type="checkbox"/>	SHORTNESS OF BREATH <input type="checkbox"/> CHEST PAIN <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> SWELLING OF FEET <input type="checkbox"/> ASTHMA <input type="checkbox"/>	HEART MURMUR <input type="checkbox"/> RHEUMATIC FEVER <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> LAST CHEST X-RAY _____
NECK	LUMPS <input type="checkbox"/>	GOITER <input type="checkbox"/>	PAIN OR STIFFNESS <input type="checkbox"/>
BREAST	LUMPS <input type="checkbox"/>	PAIN <input type="checkbox"/>	NIPPLE DISCHARGE <input type="checkbox"/>
ABDOMEN	NAUSEA <input type="checkbox"/> VOMITING <input type="checkbox"/> PAIN WHEN SWALLOWING <input type="checkbox"/> DIFFICULTY SWALLOWING <input type="checkbox"/> INDIGESTION <input type="checkbox"/>	ABDOMINAL PAIN <input type="checkbox"/> HIATAL HERNIA <input type="checkbox"/> ULCER <input type="checkbox"/> GAS <input type="checkbox"/> BLOATING <input type="checkbox"/>	CONSTIPATION <input type="checkbox"/> DIARRHEA <input type="checkbox"/> HEMORRHOIDS <input type="checkbox"/> BLOOD IN STOOLS <input type="checkbox"/> BLACK STOOLS <input type="checkbox"/>

CONTINUE REVIEW OF SYSTEMS: *Please check all boxes that apply*

URINARY/GYN	BLOOD IN URINE <input type="checkbox"/>	# OF PREGNANCIES _____	
	BURNING WITH URINATION <input type="checkbox"/>	# OF MISCARRIAGES _____	SPOTTING <input type="checkbox"/>
	FREQUENT URINATION <input type="checkbox"/>	# OF ABORTIONS _____	CRAMPING <input type="checkbox"/>
	DIFFICULTY STARTING TO URINATE <input type="checkbox"/>	# OF CHILDREN _____	DISCHARGE <input type="checkbox"/>
	BLADDER/ KIDNEY INFECTIONS <input type="checkbox"/>	LAST MENSTRUAL PERIOD _____	VAGINAL INFECTIONS <input type="checkbox"/>
	GETTING UP AT NIGHT TO URINATE <input type="checkbox"/>	DURATION _____	LAST PAP SMEAR _____
	SENSE OF FULL BLADDER <input type="checkbox"/>	INTERVAL _____	
SKIN	RASH <input type="checkbox"/>	ITCHING <input type="checkbox"/>	CHANGE IN HAIR OR NAILS <input type="checkbox"/>
NEURO-MUSCULAR	JOINT STIFFNESS <input type="checkbox"/>	SWELLING <input type="checkbox"/>	NIGHT CRAMPS <input type="checkbox"/>
	JOINT PAIN <input type="checkbox"/>	BACK PAIN <input type="checkbox"/>	VARICOSE VEINS <input type="checkbox"/>
HEMATOLOGICAL	EASY BRUISING OR BLEEDING <input type="checkbox"/>	ANEMIA <input type="checkbox"/>	PAST INFUSION <input type="checkbox"/>
			TRANSFUSION REACTIONS <input type="checkbox"/>
ENDOCRINE	THYROID PROBLEMS <input type="checkbox"/>	HOT OR COLD INTOLERANCE <input type="checkbox"/>	EXCESSIVE THIRST OR HUNGER <input type="checkbox"/>
PSYCHIATRIC	ANXIETY <input type="checkbox"/>	DEPRESSION <input type="checkbox"/>	MEMORY LOSS <input type="checkbox"/>
	NERVOUSNESS <input type="checkbox"/>		

PATIENT'S SIGNATURE: _____

PHYSICIAN'S SIGNATURE: _____