



Name (Please Print): _____

Patient Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

FAVORITE PHARMACY

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

- | | | | |
|---------------------------------------|-------------|--|-------------|
| <input type="checkbox"/> Chickenpox | Date: _____ | <input type="checkbox"/> Meningococcus | Date: _____ |
| <input type="checkbox"/> Flu Shot | Date: _____ | <input type="checkbox"/> MMR (Measles, Mumps, Rubella) | Date: _____ |
| <input type="checkbox"/> Gardasil/HPV | Date: _____ | <input type="checkbox"/> Pneumonia | Date: _____ |
| <input type="checkbox"/> Hepatitis A | Date: _____ | <input type="checkbox"/> Tdap (Tetanus and pertussis) | Date: _____ |
| <input type="checkbox"/> Hepatitis B | Date: _____ | <input type="checkbox"/> Tetanus | Date: _____ |
| | | <input type="checkbox"/> Zostavax (Shingles) | Date: _____ |

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

- | | | | |
|--|----------------------------|-----------------------------------|---|
| Last PAP Smear | Date: _____ | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Bleeding between periods |
| Last Mammogram | Date: _____ | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Heavy periods |
| Age of first menstrual period: _____ | | | <input type="checkbox"/> Extreme menstrual pain |
| Date of last menstrual period or age of menopause: _____ | | | <input type="checkbox"/> Vaginal itching, burning, or discharge |
| Number of pregnancies: _____ births: _____ | | | <input type="checkbox"/> Wake in the night to go to the bathroom |
| miscarriages: _____ abortions: _____ | | | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Cesarean sections | If yes, then number: _____ | | <input type="checkbox"/> Breast lump or nipple discharge |
| | | | <input type="checkbox"/> Painful intercourse |
| | | | <input type="checkbox"/> Sexually active |
| | | | Current sexual partner is <input type="checkbox"/> Female <input type="checkbox"/> Male |
| | | | Do you use condoms? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | Other Birth control method used: _____ |
| | | | <input type="checkbox"/> Interested in being screened for STD's |

Initial & Date Here: _____

Name (Please Print): _____

PAST MEDICAL HISTORY

Please check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Leg/Foot Ulcers |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Has Pacemaker | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Clots (or DVT) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hiatal Hernia or Reflux Disease | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Reflux or Ulcers |
| <input type="checkbox"/> Diabetes - Insulin | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes – Non-Insulin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Overactive Thyroid | <input type="checkbox"/> Other |

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Father	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Mother	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Brother/Sister	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Brother/Sister	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Other: _____	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke

SOCIAL HISTORY

<p>Occupation</p> <p>_____</p> <p>Education <input type="checkbox"/> Less than 8th grade <input type="checkbox"/> High school <input type="checkbox"/> 2 year college <input type="checkbox"/> 4 year college <input type="checkbox"/> Post graduate</p> <p>Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic partner</p> <p>Exercise Level <input type="checkbox"/> None (No exercise) <input type="checkbox"/> Occasional exercise <input type="checkbox"/> Moderate exercise <input type="checkbox"/> High level exercise</p>	<p>Caffeine</p> <p>Occasional <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy</p> <p># of cups/cans per day? _____</p> <p>Alcohol</p> <p>Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, how often? <input type="checkbox"/> Occasionally <input type="checkbox"/> < 3 times a week <input type="checkbox"/> > 3 times a week</p> <p>How many drinks per week? _____</p> <p>Tobacco</p> <p>Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If not currently, did you ever use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Cigarettes - _____ pks./day</p> <p><input type="checkbox"/> Chew - _____/day</p> <p><input type="checkbox"/> Cigars - _____/day</p> <p><input type="checkbox"/> # of years _____</p> <p>Or year quit _____</p> <p>Drugs</p> <p>Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list:</p> <p>_____</p> <p>_____</p>
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Notes:

Initial & Date Here: _____

Name (Please Print): _____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic

- Frequent Sneezing
- Hives
- Itching
- Runny Nose
- Sinus Pressure

Cardiovascular

- Arm Pain on Exertion
- Chest Pain on Exertion
- Chest Heaviness/Pressure on Exertion
- Irregular Heart Beats (Palpitations)
- Known Heart Murmur
- Light-headed on Standing
- Shortness of Breath When Lying Down
- Shortness of Breath When Walking
- Swelling (edema)

Constitutional

- Exercise Intolerance
- Fatigue
- Fever
- Weight Gain (____lbs)
- Weight Loss (____lbs)

Eyes

- Dry Eyes
- Irritation
- Vision Change
- Date of Last Exam: _____

Ears/Nose/Mouth/Throat

- Bleeding Gums
- Difficulty Hearing
- Dizziness
- Dry Mouth
- Ear Pain
- Frequent Infections
- Frequent Nosebleeds
- Hoarseness
- Mouth Breathing
- Mouth Ulcers
- Nose/Sinus Problems
- Ringing in Ears

Endocrine

- Fatigue
- Increased Thirst/Hunger/Urination

Gastrointestinal

- Abdominal Pain
- Black or Tarry Stool
- Blood in Stool
- Change in Appetite
- Frequent Indigestion
- Hemorrhoids
- Trouble Swallowing
- Vomiting
- Vomiting Blood

Genitourinary

- Blood in Urine
- Difficulty Urinating
- Incomplete Emptying
- Increased Urinary Frequency
- Urinary Loss of Control

Hematologic/Lymphatic

- Easy Bruising/Bleeding
- Swollen Glands

Integumentary (Skin)

- Changes in Moles
- Dry Skin
- Eczema
- Growth/Lesions
- Itching
- Jaundice (Yellow Skin/Eyes)
- Rash

Musculoskeletal

- Back Pain
- Joint Pain
- Muscle Aches
- Muscle Weakness

Neurological

- Dizziness
- Fainting
- Headaches
- Memory Loss
- Migraines
- Numbness
- Restless Legs
- Seizures
- Weakness

Psychiatric

- Alcohol Overuse
- Anxiety/Stress
- Depression
- Do Not Feel Safe in Relationship
- Mania
- Sleep Problems

Respiratory

- Cough
- Coughing Up Blood
- Shortness of Breath
- Sleep Apnea
- Snoring
- Wheezing

Please add any other information about your health that you would like your provider to know here:

Signature

Date