HEALTH HISTORY

*****ALL INFORMATION ON THIS FORM NEEDS TO BE COMPLETED PRIOR TO SEEING THE DOCTOR*****
******DO NOT LEAVE ANY SECTION BLANK******

Patient Name ________________________________ Date of Birth _________________ Date ___________________

MEDICATIONS (Include over-the-counter medications & herbs)	*DOCUMENT INSTRUCTIONS AND DOSAGE*	
( ) NO MEDICATIONS		
Do you take any anticoagulants (*i.e. Aspirin, Coumadin, Plavix*)? If so, please list:		
Pharmacy:	Phone#	City:

ALLERGIES	DOCUMENT THE TYPE OF REACTION YOU HAVE
( ) NO KNOWN ALLERGIES	

FAMILY HISTORY CHECK (√) YES OR NO TO CONDITIONS RELATED TO YOUR IMMEDIATE FAMILY

☐ **Unknown Family History**

	Y N	FAMILY MEMBER(S)	AGE AT DEATH (if applicable)
Asthma	☐ ☐		
Bone Cancer	☐ ☐		
Breast Cancer	☐ ☐		
Colon Cancer	☐ ☐		
Diabetes	☐ ☐		
Heart Disease	☐ ☐		
Hypertension	☐ ☐		
Kidney Disease	☐ ☐		
Leukemia	☐ ☐		
Lung Cancer	☐ ☐		
Lymphatic Cancer	☐ ☐		
Ovarian Cancer	☐ ☐		
Pancreatic Cancer	☐ ☐		
Prostate Cancer	☐ ☐		
Rectal Cancer	☐ ☐		
Skin Cancer	☐ ☐		
Stomach Cancer	☐ ☐		
Other Cancer	☐ ☐		
Difficulties with Anesthesia	☐ ☐		

Patient Name ______________________________ Date of Birth ________________ Date __________________

SOCIAL HISTORY CHECK (√) ALL BOXES AND COMPLETE ALL APPLICABLE QUESTIONS REGARDING YOUR SOCIAL HISTORY

Tobacco Use: ☐ Current ☐ Previous ☐ Never
If previous smoker: Year quit _________ Packs per year______
If current smoker: Year started _________
☐ Cigarettes - Packs/day_______ ☐ Cigars - # per week_______
☐ Smokeless/Chewing – Amt per day_________
Counseled to quit/cut down: ☐ Yes ☐ No
Passive smoke exposure: ☐ Yes ☐ No
Alcohol use: ☐ Yes ☐ No
Average drink (s) per day: ___________
Type: ___________________________
Drink daily: ☐ Yes ☐ No
Counseled: ☐ Yes ☐ No
Drug use: ☐ Yes ☐ No Type: _______________________
Comments: ____

Caffeine use (#drinks/daily): ___________________________
HIV/AIDS high risk: ☐ Yes ☐ No
Exercise (#times/week): ______________________________
Seatbelt use: ☐ Frequently ☐ Occasionally ☐ Rarely
Sun Exposure: ☐ Frequently ☐ Occasionally ☐ Rarely
Living arrangements: ☐ Single and lives alone
☐ Single and lives with someone
☐ Married and lives with spouse
☐ Married and lives with family
☐ Divorced and lives alone
☐ Divorced and lives with someone
☐ Widowed and lives alone
☐ Widowed and lives with someone
☐ Other

PAST MEDICAL HISTORY CHECK (√) CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST

☐ AIDS	☐ Crohn's Disease	☐ HIV Positive	☐ Pulmonary Fibrosis
☐ Alcoholism	☐ DVT/Phlebitis	☐ Hypertension	☐ Pulmonary Nodule
☐ Anemia	☐ Depression	☐ Interstitial Lung Disease	☐ Rheumatic Fever
☐ Angina/Chest pain	☐ Diabetes	☐ Jaundice	☐ Sarcoidosis
☐ Anorexia/Bulimia	☐ Diverticulitis	☐ Kidney Disease-if so, are you on dialysis? _______	☐ Scarlet Fever
☐ Arthritis	☐ Diverticulosis		☐ Seizure Disorder
☐ Asthma	☐ Emphysema	☐ Kidney Stone	☐ Sexually Transmitted Disease
☐ Atrial Fibrillation	☐ Epilepsy	☐ Liver Disease	
☐ Bleeding Disorders	☐ Eye Problems	☐ Lupus (SLE)	☐ Skin Cancer
☐ Bone Disease	☐ Faint/Dizziness	☐ Measles	☐ Sleep Apnea-if so, do you use a CPAP? ____
☐ Breast Cysts	☐ GERD	☐ Migraines/Headaches	
☐ Breast Mass	☐ GI Bleed	☐ Mitral Valve Prolapse	☐ Soft Tissue Lesions
☐ Bronchitis	☐ Glaucoma	☐ Multiple Sclerosis	☐ Stent
☐ Cancer	☐ Goiter	☐ Mumps	☐ Stroke
☐ Cataracts	☐ Gonorrhea	☐ Numbness/Weakness	☐ Thyroid Problems
☐ Chemical Dependency	☐ Gout	☐ Osteoporosis	☐ TIA
☐ Chicken Pox	☐ Hearing Problems	☐ Pacemaker	☐ Tonsillitis
☐ Chronic Back Pain	☐ Heart Attack	☐ Pleural Effusion	☐ Transfusions
☐ Congestive Heart Failure	☐ Heart Disease	☐ Pneumonia	☐ Tuberculosis
☐ Coronary Artery Disease	☐ Heartburn	☐ Pneumothorax	☐ Typhoid Fever
☐ Chronic Renal Failure	☐ Hepatitis	☐ Polio	☐ Ulcers
☐ Cirrhosis	☐ Hernia	☐ Prostate Problem	☐ Urinary Tract Infection
☐ Colon Polyps	☐ Herpes	☐ Psychiatric Care	☐ Vaginal Infection
☐ COPD-if so, do you use oxygen? ____ L/NC_____	☐ High Cholesterol	☐ Pulmonary Emboli	☐ Venereal Disease

PAST SURGICAL HISTORY CHECK (√) ALL SURGERIES YOU HAVE HAD IN THE PAST

☐ Amputation	☐ Colon Resection	☐ Knee Arthroscopy	☐ Splenectomy
☐ AV Fistula	☐ Colostomy/Ileostomy	☐ Knee Replacement	☐ TAH
☐ AV Graft	☐ D&C	☐ Laparoscopy	☐ Thyroidectomy
☐ Appendectomy	☐ Defibrillator	☐ Laparotomy	☐ Transplant - type
☐ Axillary Dissection	☐ Esophagectomy	☐ Liver Transplant	☐ ____________________
☐ Bone Fracture - explain ________________	☐ Gastrectomy	☐ Lumpectomy	☐ Tonsillectomy
	☐ Gastric Bypass	☐ Lung Resection	☐ Tunneled Dialysis Catheter
☐ Breast Augmentation	☐ Heart Surgery	☐ Mastectomy	☐ Heart Stent
☐ Bronchoscopy	☐ Hemorrhoidectomy	☐ Neck/Back Surgery	☐ Urinary Incontinence Surgery
☐ CABG	☐ Hepatectomy	☐ Nephrectomy	☐ Other Surgery:
☐ Carotid Endarterectomy	☐ Hernia Repair-type	☐ Pacemaker	____________________
☐ Carpal Tunnel	__________________	☐ Pancreatectomy	____________________
☐ Cataract Extraction	☐ Hip Replacement	☐ Pyloroplasty	☐ Anesthesia problems-no
☐ Cholecystectomy	☐ Kidney Transplant	☐ Reduction Mammoplasty	☐ Anesthesia problems-yes

Patient Name ________________________________ Date of Birth _________________ Date ________________

REVIEW OF SYSTEMS — CHECK (√) YES OR NO TO SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

CONSTITUTION

Y N
- ☐ ☐ Fever
- ☐ ☐ Chills
- ☐ ☐ Sweats
- ☐ ☐ Anorexia
- ☐ ☐ Fatigue
- ☐ ☐ Weakness
- ☐ ☐ Malaise
- ☐ ☐ Weight loss

EAR, NOSE, THROAT
- ☐ ☐ Ringing in ears
- ☐ ☐ Ear Discharge
- ☐ ☐ Earache
- ☐ ☐ Decreased hearing
- ☐ ☐ Nasal congestion
- ☐ ☐ Nosebleeds
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Hoarseness
- ☐ ☐ Sore throat
- ☐ ☐ Bleeding gums

EYES
- ☐ ☐ Vision loss-1 eye
- ☐ ☐ Double vision
- ☐ ☐ Eye irritation
- ☐ ☐ Vision loss-both eyes
- ☐ ☐ Blurring
- ☐ ☐ Eye pain
- ☐ ☐ Halos
- ☐ ☐ Discharge
- ☐ ☐ Light sensitivity

RESPIRATORY
- ☐ ☐ Cough
- ☐ ☐ Shortness of breath
- ☐ ☐ Coughing up blood
- ☐ ☐ Chest discomfort
- ☐ ☐ Sleep disturbances
- ☐ ☐ Wheezing
- ☐ ☐ Excessive sputum
- ☐ ☐ Excessive snoring

CARDIOVASCULAR

Y N
- ☐ ☐ Difficulty breathing
- ☐ ☐ Near Fainting
- ☐ ☐ Chest pain/discomfort
- ☐ ☐ Racing/skipping heart beat
- ☐ ☐ Fatigue
- ☐ ☐ Lightheadedness
- ☐ ☐ Shortness of breath with exertion
- ☐ ☐ Palpitations
- ☐ ☐ Swelling of hands or feet
- ☐ ☐ Fainting
- ☐ ☐ Leg cramps
- ☐ ☐ Weight gain

HEMATOLOGIC/LYMPHATIC
- ☐ ☐ Enlarged lymph nodes
- ☐ ☐ Bleeding
- ☐ ☐ Skin discoloration
- ☐ ☐ Abnormal bruising
- ☐ ☐ Fevers

SKIN
- ☐ ☐ Excessive perspiration
- ☐ ☐ Night sweats
- ☐ ☐ Suspicious lesions
- ☐ ☐ Changes in nail beds
- ☐ ☐ Dryness
- ☐ ☐ Poor wound healing
- ☐ ☐ Skin cancer
- ☐ ☐ Itching
- ☐ ☐ Flushing
- ☐ ☐ Rash

ALLERGY/IMMUNOLOGIC
- ☐ ☐ Persistent infections
- ☐ ☐ Hives
- ☐ ☐ Rash
- ☐ ☐ Seasonal allergies
- ☐ ☐ HIV exposure

GASTROINTESTINAL
- ☐ ☐ Excessive appetite
- ☐ ☐ Loss of appetite

GASTROINTESTINAL

Y N
- ☐ ☐ Indigestion
- ☐ ☐ Vomiting blood
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Yellowish skin color
- ☐ ☐ Gas
- ☐ ☐ Abdominal pain
- ☐ ☐ Abdominal bloating
- ☐ ☐ Hemorrhoids
- ☐ ☐ Diarrhea
- ☐ ☐ Change in bowel habits
- ☐ ☐ Constipation
- ☐ ☐ Dark tarry stools
- ☐ ☐ Bloody stools

GENITO-URINARY
- ☐ ☐ Painful urination
- ☐ ☐ Blood in urine
- ☐ ☐ Urinary frequency
- ☐ ☐ Urinary hesitancy
- ☐ ☐ Incontinence
- ☐ ☐ Genital sores
- ☐ ☐ Decreased libido

MEN only
- ☐ ☐ Erection dysfunction
- ☐ ☐ Lump in testicles
- ☐ ☐ Penis discharge
- ☐ ☐ Breast lump

WOMEN only
- ☐ ☐ Abnormal pap smear
- ☐ ☐ Abnormal mammogram
- ☐ ☐ Extreme menstrual pain
- ☐ ☐ Bleeding between periods
- ☐ ☐ Breast lump
- ☐ ☐ Vaginal discharge
- ☐ ☐ Hot flashes
- ☐ ☐ Nipple discharge

Last menstrual period__________

Last Pap smear_______________

Last Mammogram_____________

Do you use birth control? _______

MUSCULOSKELETAL

Y N
- ☐ ☐ Muscle cramps
- ☐ ☐ Joint pain
- ☐ ☐ Joint swelling
- ☐ ☐ Back pain
- ☐ ☐ Stiffness
- ☐ ☐ Muscle weakness
- ☐ ☐ Arthritis
- ☐ ☐ Gout
- ☐ ☐ Loss of strength
- ☐ ☐ Muscle aches

NEUROLOGIC
- ☐ ☐ Difficulty with concentration
- ☐ ☐ Poor balance
- ☐ ☐ Headaches
- ☐ ☐ Disturbances in coordination
- ☐ ☐ Numbness
- ☐ ☐ Inability to speak
- ☐ ☐ Falling down
- ☐ ☐ Seizures
- ☐ ☐ Tingling
- ☐ ☐ Tremors
- ☐ ☐ Fainting
- ☐ ☐ Excessive daytime sleeping
- ☐ ☐ Memory Loss

PSYCHOLOGIC
- ☐ ☐ Anxiety/nervousness
- ☐ ☐ Thoughts of suicide
- ☐ ☐ Depression
- ☐ ☐ Thoughts of violence
- ☐ ☐ Mental disorder
- ☐ ☐ Mood swings

ENDOCRINE
- ☐ ☐ Excessive hunger
- ☐ ☐ Cold intolerance
- ☐ ☐ Heat intolerance
- ☐ ☐ Excessive urination
- ☐ ☐ Excessive thirst
- ☐ ☐ Weight change

All information is strictly confidential

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, have a change in health.

____ ________________________________

Signature of Patient, Parent, Guardian or Personal Representative — Date

____ ________________________________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

____________________ Reviewed By (Initial and Date)

____________________ Reviewed By (Initial and Date) ☐ Changes ☐ No Changes

____________________ Reviewed By (Initial and Date) ☐ Changes ☐ No Changes

____________________ Reviewed By (Initial and Date) ☐ Changes ☐ No Changes

____________________ Reviewed By (Initial and Date) ☐ Changes ☐ No Changes