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

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

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

Patient Name _____ Date of Birth _____ Date _____

REVIEW OF SYSTEMS — CHECK (✓) YES OR NO TO SYMPTOMS YOU CURRENTLY HAVE

CONSTITUTION

Y N

- ☐ ☐ Activity change
- ☐ ☐ Appetite change
- ☐ ☐ Chills
- ☐ ☐ Diaphoresis/Excessive sweating
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Weight change

HENT

Y N

- ☐ ☐ Congestion
- ☐ ☐ Dental Problem
- ☐ ☐ Drooling
- ☐ ☐ Ear discharge
- ☐ ☐ Ear pain
- ☐ ☐ Facial swelling
- ☐ ☐ Hearing loss
- ☐ ☐ Mouth sores
- ☐ ☐ Nosebleeds
- ☐ ☐ Postnasal drip
- ☐ ☐ Rhinorrhea/Runny Nose
- ☐ ☐ Sinus pressure
- ☐ ☐ Sneezing
- ☐ ☐ Sore throat
- ☐ ☐ Tinnitus/Ringing in ears
- ☐ ☐ Trouble swallowing
- ☐ ☐ Voice change

EYES

Y N

- ☐ ☐ Eye discharge
- ☐ ☐ Eye itching
- ☐ ☐ Eye pain
- ☐ ☐ Eye redness
- ☐ ☐ Photophobia/Light Sensitivity
- ☐ ☐ Visual disturbances/Changes

RESPIRATORY

Y N

- ☐ ☐ Apnea/Stop breathing in sleep
- ☐ ☐ Chest tightness
- ☐ ☐ Choking
- ☐ ☐ Cough
- ☐ ☐ Shortness of breath
- ☐ ☐ Stridor/Harsh breathing sound
- ☐ ☐ Wheezing

CARDIOVASCULAR

Y N

- ☐ ☐ Chest pain
- ☐ ☐ Leg swelling
- ☐ ☐ Palpitations

GASTROINTESTINAL

Y N

- ☐ ☐ Abdominal distension/Swelling
- ☐ ☐ Abdominal pain
- ☐ ☐ Anal bleeding/Rectal
- ☐ ☐ Blood in stool
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Nausea
- ☐ ☐ Rectal pain
- ☐ ☐ Vomiting

ENDOCRINE

Y N

- ☐ ☐ Cold intolerance
- ☐ ☐ Heat intolerance
- ☐ ☐ Polydipsia/Excessive Thirst
- ☐ ☐ Polyphagia/Excessive Hunger
- ☐ ☐ Polyuria/Excessive Urine

GENITO-URINARY

Y N

- ☐ ☐ Difficulty urinating
- ☐ ☐ Dysuria/Painful Urination
- ☐ ☐ Enuresis/Urinary Incontinence
- ☐ ☐ Flank pain (Back or side)
- ☐ ☐ Frequency
- ☐ ☐ Genital sores
- ☐ ☐ Hematuria/Blood in urine
- ☐ ☐ Urgency
- ☐ ☐ Urine decreased

MEN ONLY

Y N

- ☐ ☐ Penile discharge
- ☐ ☐ Penile pain
- ☐ ☐ Penile swelling
- ☐ ☐ Scrotal swelling
- ☐ ☐ Testicular pain

WOMEN ONLY

Y N

- ☐ ☐ Menstrual problems
- ☐ ☐ Pelvic pain
- ☐ ☐ Vaginal bleeding
- ☐ ☐ Vaginal discharge
- ☐ ☐ Vaginal pain

Last menstrual period _____
Last mammogram_____
Last Pap smear _____
Do you use birth control? ___

MUSCULOSKELETAL

Y N

- ☐ ☐ Arthralgia/Joint pain
- ☐ ☐ Back pain
- ☐ ☐ Gait problem
- ☐ ☐ Joint swelling
- ☐ ☐ Myalgia/Muscle pain
- ☐ ☐ Neck pain
- ☐ ☐ Neck stiffness

SKIN

Y N

- ☐ ☐ Color change
- ☐ ☐ Pallor
- ☐ ☐ Rash
- ☐ ☐ Wound

ALLERGY/IMMUNO

Y N

- ☐ ☐ Environ. Allergies
- ☐ ☐ Food allergies
- ☐ ☐ Immunocompromised

NEURO

Y N

- ☐ ☐ Dizziness
- ☐ ☐ Facial asymmetry
- ☐ ☐ Headaches
- ☐ ☐ Light-headedness
- ☐ ☐ Numbness
- ☐ ☐ Seizures
- ☐ ☐ Speech difficulty
- ☐ ☐ Syncope/Fainting
- ☐ ☐ Tremors
- ☐ ☐ Weakness

HEMATOLOGIC

Y N

- ☐ ☐ Adenopathy/Swollen Nodes
- ☐ ☐ Bruises/bleed easily

PSYCHOLOGIC

Y N

- ☐ ☐ Agitation
- ☐ ☐ Behavior problem
- ☐ ☐ Confusion
- ☐ ☐ Decr. concentration
- ☐ ☐ Dysphoric mood/Uneasy
- ☐ ☐ Hallucinations
- ☐ ☐ Hyperactive
- ☐ ☐ Nervous/anxious
- ☐ ☐ Self Injury
- ☐ ☐ Sleep disturbances
- ☐ ☐ Suicidal ideas