Patient Health History

Today's Date: _____

Patient Title: *(check one)* ___ Mr. ___ Mrs. ___ Ms. ___ Miss ___ Dr. ___ Prof. ___ Rev.

First Name: _____ **Nick Name**: _____

Last Name: _____ **MI**: _____ **Suffix:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mobile Phone: _____ **Home Phone:** _____

Email address you would like us to use to communicate with you?

_____

Date of Birth: _____ **Age:** _____ **Gender:** *(check one)* ___ Male ___ Female

Marital Status: *(check one)* ___ Single ___ Married ___ Divorced ___ Widowed ___ Other

Employment Status: *(check one)*
___ Employed ___ FT Student ___ PT Student ___ Other ___ Retired ___ Self Employed

Verification Question: *(check only one question, then give the answer to that question)*
___ What is the name of your favorite pet? ___ In what city were you born?
___ What high school did you attend? ___ What is your favorite movie?
___ What is your mother's maiden name? ___ On what street did you grow up?
___ What was the make of your first car? ___ When is your anniversary?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? ___ Yes ___ Former smoker ___ Never smoked

List Current Medications below, including frequency and dosage, if known.
If there is no current medications, check here ___.

1) _____ Start Date: _____
2) _____ Start Date: _____
3) _____ Start Date: _____
4) _____ Start Date: _____
5) _____ Start Date: _____
6) _____ Start Date: _____
7) _____ Start Date: _____

List previous surgeries below:

1) _____
2) _____
3) _____
4) _____
5) _____

List any known allergies you have had to any medications below.
If no allergies are known, check here ___.

1) _____
2) _____
3) _____
4) _____
5) _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently?
___ Yes ___ No If yes, when? _____

Has any doctor diagnosed you with Diabetes presently? ___ Yes ___ No

If yes, what kind? ___ Type I ___ Type II

If yes to Diabetes, was your blood lab work test hemoglobin A1c > 9.0%?
___Yes ___No ___ Unsure

If yes, other comments regarding Diabetes:
_____

Signature of Patient _____

How did you hear about our office? Or who referred you?

___ Family Member ___ Friend ___ Website ___ Phone Book ___ Other

If you selected family or friend, please include the name of the person who referred you:

_____

Medical History

Check those that apply.

MEDICAL CONDITIONS:

___ Arthritis ___ Cancer ___ Diabetes ___ Heart Disease

___ Hypertension ___ Psychiatric illness ___ Skin Disorder ___ Stroke

SURGERIES:

___ Appendectomy ___ Cardiovascular procedure ___ Cervical disc procedure ___ Hysterectomy

___ Transurethral prostate surgery ___ Laminectomies ___ Radical prostatectomy

___ Joint replacement; Please describe joint and date _____

ALLERGIES:

___ Fish and Shellfish ___ Milk ___ Peanut ___ Soy ___ Sulfites ___ Wheat/Gluten

___ Other _____

SOCIAL HISTORY:

___ caffeine used occasionally ___ caffeine used often

___ chew tobacco occasionally ___ chew tobacco often

___ drink alcohol occasionally ___ drink alcohol often

___ exercise not at all ___ exercise occasionally ___ exercise often

___ experience stress occasionally ___ experience stress often

___ smoke 1 pack or less per day ___ smoke more than 1 pack per day

___ wear seatbelt never ___ wear seatbelt usually ___ wear seatbelt always

FAMILY HISTORY:

___ arthritis (parent) ___ arthritis (sibling) ___ cancer (parent) ___ cancer (sibling)

___ cholesterol (parent) ___ cholesterol (sibling) ___ diabetes (parent) ___ diabetes (sibling)

___ heart problems (parent) ___ heart problems (sibling) ___ stroke (parent) ___ stroke (sibling)

___ high blood pressure (parent) ___ high blood pressure (sibling) ___ thyroid (parent) ___ thyroid (sibling)

___ psychiatric (parent) ___ psychiatric (sibling)

SUBSTANCE USE: Please circle past or present.

___ Alcohol (past/present) ___ Amphetamines (past/present) ___ Barbiturates (past/present)

___ Cocaine (past/present) ___ Crystal Meth (past/present) ___ Heroin (past/present)

___ Marijuana (past/present)

MALE CHILDREN:

___ under 6 years old ___ under 10 years old ___ under 19 years old

FEMALE CHILDREN:

___ under 6 years old ___ under 10 years old ___ under 19 years old

OCCUPATIONAL ACTIVITIES: Please list below.

_____

_____

RECREATIONAL/EXERCISE ACTIVITIES: Please list below.

_____

_____

OTHER HISTORY NOT INCLUDED: Please list below.

_____

_____

Review of Systems

Have you had trouble with any of the following?

Cardiovascular: No ___

	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			
Vascular Disease			

Genitourinary: No ___

	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Hematologic/lymphatic: No ___

	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Neurologic: No ___

	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			
Babinski			

Respiratory: No ___

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat: No ___

	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes: No ___

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary: No ___

	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			
Skin Lesions			

Psychiatric: No ___

	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional: No ___

	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Allergic/Immunologic: No ___

	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Gastrointestinal: No ___

	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal: No ___

	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine: No ___

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			