Patient Health History

Name: _____ Date of birth: _____ Age: _____

SS#: _____ Today's Date: _____ Sex: Male Height: _____
Marital Status: S M W D Separated Female Weight: _____

Primary Care Physician: _____ Phone number: _____

Referring Physician: _____ Phone number: _____

Other physicians, include names,
specialties, and phone numbers:
_____

Pharmacy Name: _____ Pharmacy phone: _____

Current problem or reason for visit: _____

Do you feel the need to be linked to our social worker (counseling or financial issues)? Y/N ___

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

Problem	Date of onset	Problem	Date of onset
Allergies	☐ _____	Hepatitis/Liver disease	☐ _____
Anemia/Blood disorders	☐ _____	High cholesterol	☐ _____
Arthritis	☐ _____	High blood pressure	☐ _____
Asthma	☐ _____	Irregular heart beat	☐ _____
Blood clots	☐ _____	Kidney disease	☐ _____
Cancer	☐ _____	Pancreatitis	☐ _____
Cataracts	☐ _____	Sickle cell disease	☐ _____
Colitis	☐ _____	Sinusitis	☐ _____
Diabetes	☐ _____	Stroke	☐ _____
Emphysema	☐ _____	Thyroid	☐ _____
Heartburn/GERD/Reflux	☐ _____	Tuberculosis	☐ _____

Glaucoma ☐ _____ Ulcers ☐ _____

Heart Disease ☐ _____

Other past medical history: _____

_____

_____

Any unusual childhood illnesses or infections? _____

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

1. _____

2. _____

3. _____

4. _____

5. _____

Have you:

Ever had a blood transfusion: ☐ Yes ☐ No If yes, when: _____

Traveled outside the US in the last three years? ☐ Yes ☐ No If yes, where: _____

REPRODUCTIVE HISTORY:

Number of pregnancies: _____ Number of children: _____

Age at first pregnancy: _____ Did you breast feed? _____

Age at first period: _____ Age at menopause: _____

Age of last period: _____

Hysterectomy: ☐ Yes ☐ No Ovaries Intact? _____

Hormone use: ☐ Yes ☐ No Sex Drive ☐ Yes ☐ No

Birth Control Method: _____

Preventive Health Maintenance: *please provide dates for each answer or write "none"*

Female	**Male**
Last mammogram: _____	Last colonoscopy: _____
Last breast exam: _____	Last stool for occult blood: _____
Last Pap smear: _____	Last prostate exam: _____
Last pelvic exam: _____	Last chest x-ray: _____
Last colonoscopy: _____	Last pneumonia vaccine: _____
Last stool for occult blood: _____	
Last bone density scan: _____	
Last chest x-ray: _____	
Last pneumonia vaccine: _____	

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 ☐ Spouse ☐ Child ☐ Sibling(s) ☐ Parent(s) ☐

Friend ☐ Other ☐ _____

City of residence: _____ Have you completed an advanced directive? Y / N

Have you completed a living will? Y / N

Smoking history

Cigarettes ☐ How many years? _____

Cigars ☐ Number per day _____

Pipes ☐ If quit, when _____

Alcohol history

Beer ☐ How many years? _____

Wine ☐ How much per day/week/month? _____

Liquor ☐ If quit, when_____

Recreational drug use ☐ Blood transfusions ☐ HIV testing ☐

ALLERGIES TO MEDICATIONS: *please write "none" if none*

Name of drug(s)/type of reaction:

_____ _____

_____ _____

_____ _____

MEDICATIONS/SUPPLEMENTS: *please include over the counter drugs*

Name of drug	Dose (mg or mcg)	How many times daily	How long taking for

VACCINATIONS: *Please provide date of last vaccination*

Influenza: _____ Shingles: _____

FAMILY HISTORY:

Relationship	Illness	Diagnosis Age	Deceased?
Mother:	_____	_____	Y ☐ N ☐
Father:	_____	_____	Y ☐ N ☐
Grandmother (P):	_____	_____	Y ☐ N ☐
Grandfather (P):	_____	_____	Y ☐ N ☐
Grandmother (M):	_____	_____	Y ☐ N ☐
Grandfather (M):	_____	_____	Y ☐ N ☐
Brothers:	_____	_____	Y ☐ N ☐
Sisters:	_____	_____	Y ☐ N ☐
Children:	_____	_____	Y ☐ N ☐

Any other relatives with: *Please check all the boxes that apply*

Anemia ☐ Diabetes ☐ Blood clots ☐ Heart disease ☐

Blood disorders ☐ Hypertension ☐ Stroke ☐

Cancer ☐ If so, what kind(s): _____

REVIEW OF SYSTEMS

Constitutional		**Breast**		**Skin**	
Weight Loss	Y ☐ N ☐	Mass	Y ☐ N ☐	Rash	Y ☐ N ☐
Poor energy level	Y ☐ N ☐	Pain	Y ☐ N ☐	Nodules	Y ☐ N ☐
Fever	Y ☐ N ☐	Nipple discharge	Y ☐ N ☐	Itchiness	Y ☐ N ☐
Chills	Y ☐ N ☐	Change is size	Y ☐ N ☐	Lesions	Y ☐ N ☐
Night sweats	Y ☐ N ☐	Change in shape	Y ☐ N ☐		

Eyes		**Gastrointestinal**		**Neurological**	
Double vision	Y ☐ N ☐	Nausea	Y ☐ N ☐	Confusion	Y ☐ N ☐
Vision loss	Y ☐ N ☐	Vomiting	Y ☐ N ☐	Seizures	Y ☐ N ☐
Flashing lights	Y ☐ N ☐	Jaundice	Y ☐ N ☐	Fainting spells	Y ☐ N ☐
		Abdominal pain	Y ☐ N ☐	Tremors	Y ☐ N ☐
		Maroon or black stools	Y ☐ N ☐	Speech change	Y ☐ N ☐
		Constipation	Y ☐ N ☐	Headache	Y ☐ N ☐
		Abdominal cramping	Y ☐ N ☐	Hiccups	Y ☐ N ☐
		Diarrhea	Y ☐ N ☐	Abnormal gait	Y ☐ N ☐
		Stomach pain	Y ☐ N ☐	Weakness	Y ☐ N ☐
		Vomiting blood	Y ☐ N ☐	Sensory change	Y ☐ N ☐
		Difficulty swallowing	Y ☐ N ☐		

ENT/Mouth		**Urinary**		**Psychiatric**	
Ringing in ears	Y ☐ N ☐	Painful urination	Y ☐ N ☐	Depression	Y ☐ N ☐
Oral ulcers	Y ☐ N ☐	Blood in urine	Y ☐ N ☐	Anxiety	Y ☐ N ☐
Nasal drip	Y ☐ N ☐	Impotence	Y ☐ N ☐	Difficulty	Y ☐ N☐
Hearing loss	Y ☐ N ☐	Loss of bladder control	Y ☐ N ☐	concentrating	
Bleeding gums	Y ☐ N ☐	Increased frequency	Y ☐ N ☐		
Mouth pain	Y ☐ N ☐				
Nose bleeds	Y ☐ N ☐				
Sore throat	Y ☐ N ☐				
Difficulty swallowing	Y ☐ N ☐				
Hoarseness	Y ☐ N ☐				
Sinus pain	Y ☐ N ☐				

Cardiovascular		**Gynecological**		**Endocrine**	
Chest pain	Y ☐ N ☐	Vaginal discharge	Y ☐ N ☐	Excessive urine	Y ☐ N ☐
Leg swelling	Y ☐ N ☐	Pelvic pain	Y ☐ N ☐	Excessive thirst	Y ☐ N ☐
Palpitations	Y ☐ N ☐	Abnormal bleeding	Y ☐ N ☐	Hot flashes	Y ☐ N ☐
Calf discomfort	Y ☐ N ☐	Vaginal dryness	Y ☐ N ☐	Heat/cold intolerance	Y ☐ N ☐
Fainting spells	Y ☐ N ☐				
Arm swelling	Y ☐ N ☐				

Respiratory		**Musculoskeletal**		**Hematological**	
Cough	Y ☐ N ☐	Muscle pain	Y ☐ N ☐	Nose bleeds	Y ☐ N ☐
Wheezing	Y ☐ N ☐	Spine tenderness	Y ☐ N ☐	Bleeding gums	Y ☐ N ☐
Shortness of breath	Y ☐ N ☐	Swollen joints	Y ☐ N ☐	Purple spots on hands	Y ☐ N ☐

REVIEW OF SYSTEMS CONT.

Respiratory	**Musculoskeletal**	**Hematological**
Coughing up blood Y ☐ N ☐	Joint pain Y ☐ N ☐	Bruising Y ☐ N ☐
Pain with breathing Y ☐ N ☐	Bone pain Y ☐ N ☐	

Lymphatic

Enlarged lymph nodes Y ☐ N ☐
Swelling in arms Y ☐ N ☐

ADDITIONAL NOTES: *Please use this space to complete any additional notes that were not completed above. Please mark what section they correspond to.*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient signature: _____

Patient printed name: _____

Date: _____