Patient Health History Form

Name _____ Date of Birth_____ Today's Date_____
Present Complaint _____
Preferred Pharmacy (please include address) _____
Medications and Dosages (may attach list or write on back): _____
_____
Medication Allergies: ________
Active Problems: Please check any of the following which are currently active problems:

Eyes
□ Change in vision

Respiratory
□ Cough/Wheeze
□ Coughing up blood

Skin
□ Rash
□ New/change in mole

General
□ Recent Fever/Sweats
□ Unexplained weight loss
□ Unexplained fatigue/weakness

Gastrointestinal
□ Heartburn/reflux
□ Blood or change in bowel
□Nausea/vomiting/diarrhea
□ Abdominal pain

Neurological
□ Headaches
□ Memory Loss
□ Fainting

Genitourinary
□ Painful/bloody urination
□ Leaking urine
□ Nighttime urination
□ Discharge: penis or vaginal
□Unusual vaginal bleeding
□ Concern with sexual functions

Ears/Nose/Throat/Mouth
□ Difficulty hearing/ringing in ears
□ Hay fever/allergies/congestion
□ Trouble swallowing

Psychiatric
□ Anxiety/Stress
□ Sleep problems

Breast
□ Breast lump
□ Nipple Discharge

Musculoskeletal
□ Muscle/joint pain
□ Recent back pain

Endo
□ Cold/Heat intolerance
□ Increase thirst/appetite

Immunizations (Please list date of last vaccination)
□ Hepatitis A_____ □ Hepatitis B_____ □ Influenza (flu) _____ □ MMR_____
□ Meningitis_____ □ Tetanus (Td)_____ □ Varicella (chicken pox) shot or illness_____
□ Pneumovax (pneumonia)_____ □ Tdap (tetanus and pretussis)_____

Health Maintenance Screening Tests: Please list the date and indicate if results were abnormal
Lipid (cholesterol)_____ Abnormal? □Yes □No PSA(prostate) _____ Abnormal? □Yes □No
Colonoscopy _____ Abnormal? □Yes □No Dexa Scan _____ Abnormal? □Yes □No
Mammogram_____ Abnormal? □Yes □No Pap Smear_____ Abnormal? □Yes □No

Personal Medical History:
□ Heart Disease: (Specify) _____ □ High Blood Pressure □ High Cholesterol
□Asthma/Lung Disease □ Diabetes □ Thyroid Problems
□ Cancer (Specify)_____ □ Kidney Disease □ Other_____

Surgical History: Please list all prior operations and dates -

_____

Family History: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions

Alcoholism _____ High Cholesterol_____

Cancer, specify type _____ High blood pressure _____

Heart Disease _____ Stroke _____

Depression/suicide_____ Bleeding/clotting disorder _____

Genetic disorders _____ Asthma/COPD _____

Diabetes _____ Others: _____

Social History:

Use of Tobacco:

Cigarettes □ Never □ Quit Date _____ □ Current smoker: packs/day____ # of years ____

Other Tobacco: □ Pipe □ Cigar □ Snuff □Chew □ Interested in quitting

Alcohol Use: Do you drink alcohol? □ No □ Yes # drinks/week _____

Is your alcohol use a concern to you or others? □No □Yes

Drug Use: Do you use any recreational drugs? □ No □ Yes

Have you ever used needles to inject drugs? □ No □ Yes

Sexual Activity: □ Yes □ No □ Not Currently Current sex partner(s) are: □ Male □ Female

Birth Control Method: _____ □ None Needed

Have you ever had any sexually transmitted diseases (STD's)? □ No □ Yes

Are you interested in being screened for sexually transmitted diseases? □ No □ Yes

Other Concerns:

Caffeine Intake: □ None □ Coffee/ tea /soda _____ cups /day

Weight: Are you satisfied with your weight? □ No □ Yes

Diet: How do you rate your diet? □ Good □ Fair □ Poor

Do you eat or drink four servings of diary or soy daily or take calcium supplements?□No □Yes

Exercise: Do you exercise regularly? □ No □ Yes How long (minutes)?_____ How often?____

What type of exercise?_____ If you do not exercise, why? _____

Safety: Do you use a bike helmet? □No □Yes Do you use seatbelts consistently? □No □Yes

Is violence at home a concern? □ No □ Yes Have you ever been abused? □ No □ Yes

Do you have a gun in your home? □ No □ Yes

Do you have a living will or durable power of attorney for your healthcare? □ No □ Yes

Socioeconomics: Occupation: _____ Employer: _____

Years of education/highest degree: _____ Spouse/partner's Name: _____

Number of children/ages: _____ Who lives in the home with you?_____

Women's History: # Pregnancies_____ # Deliveries _____ # Abortion ____ # Miscarriages ___

Age at start of periods: _____ Age at end of periods: _____