

# Patient Health History Form

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
First MI Last MM/DD/YYYY

Height: \_\_\_\_\_ Gender: \_\_\_ Female \_\_\_ Male Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
MM/DD/YYYY

Weight: \_\_\_\_\_ Family/Primary Care Physician: \_\_\_\_\_  
lbs.

Relatives seen in this organization: \_\_\_\_\_  
(List names of immediate family members)

Reason for Today's Visit: \_\_\_\_\_

## GENERAL MEDICAL HISTORY:

**SOCIAL HISTORY:** Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed

Current work status: \_\_\_ Student \_\_\_ Homemaker \_\_\_ Retired \_\_\_ Unemployed \_\_\_ Disabled

Employed: Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Do you smoke? \_\_\_ Yes \_\_\_ No Alcoholic Beverages? \_\_\_ Yes \_\_\_ No

If yes, how much? \_\_\_\_\_ Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor \_\_\_\_\_

Date Quit? \_\_\_\_\_ If yes, how much? \_\_\_\_\_  
MM/DD/YYYY

How many cups of coffee or tea do you drink daily? \_\_\_\_\_

**ALLERGIES:** Are you allergic to Latex? \_\_\_ No \_\_\_ Yes

*List Allergies (including medications)*

**No known allergies**

*Describe reactions:*

- |          |          |
|----------|----------|
| 1) _____ | a. _____ |
| 2) _____ | a. _____ |
| 3) _____ | a. _____ |
| 4) _____ | a. _____ |

**IMMUNIZATIONS:** Do you have all your childhood immunizations? \_\_\_ Yes \_\_\_ No

Date of last tetanus? \_\_\_\_\_ Date of last pneumonia vaccine? \_\_\_\_\_

## ILLNESSES / CONDITIONS:

*Are you affected by any of the following: (check all that apply)*

**No Medical Problems**

- |                           |                         |                          |
|---------------------------|-------------------------|--------------------------|
| ___ Abnormal heart rhythm | ___ Emphysema           | ___ Lung disease         |
| ___ Alcoholism            | ___ Endometriosis       | ___ Osteoarthritis       |
| ___ Anemia                | ___ Gout                | ___ Osteoporosis         |
| ___ Anorexia/Bulimia      | ___ Heart attack        | ___ Ovarian cysts        |
| ___ Anxiety               | ___ Heart failure       | ___ Rheumatoid arthritis |
| ___ Asthma                | ___ Hepatitis           | ___ Seizures             |
| ___ Bleeding disorders    | ___ High blood pressure | ___ Sleep Apnea          |
| ___ Blood clots           | ___ HIV                 | ___ Stents               |
| ___ Bronchitis            | ___ Irritable bowel     | ___ Stomach ulcers       |
| ___ Cancer (where: _____) | ___ Kidney failure      | ___ Stroke               |
| ___ Depression            | ___ Kidney stones       | ___ Thyroid disease      |
| ___ Diabetes              | ___ Liver disease       | ___ Tuberculosis         |

Other: \_\_\_\_\_

**FAMILY HISTORY:**

None

(Check the condition and then check all relatives that apply)

	Father	Mother	Brother	Sister	Uncle	Aunt	Son	Daughter	Grandparent
___ Cancer:	___	___	___	___	___	___	___	___	___
(Type: _____)									
___ Glaucoma:	___	___	___	___	___	___	___	___	___
___ Diabetes:	___	___	___	___	___	___	___	___	___
___ Tuberculosis:	___	___	___	___	___	___	___	___	___
___ Stroke:	___	___	___	___	___	___	___	___	___
___ Heart Disease:	___	___	___	___	___	___	___	___	___
___ HTN:	___	___	___	___	___	___	___	___	___
___ Epilepsy:	___	___	___	___	___	___	___	___	___
___ Depression:	___	___	___	___	___	___	___	___	___
___ Suicide:	___	___	___	___	___	___	___	___	___
___ Birth Defect:	___	___	___	___	___	___	___	___	___
___ Other:	___	___	___	___	___	___	___	___	___

Please explain other: \_\_\_\_\_

**SURGICAL HISTORY:**

None

List Type of Surgeries:

Dates:

Hospital / Facility:

- |          |          |          |
|----------|----------|----------|
| 1) _____ | a. _____ | b. _____ |
| 2) _____ | a. _____ | b. _____ |
| 3) _____ | a. _____ | b. _____ |
| 4) _____ | a. _____ | b. _____ |
| 5) _____ | a. _____ | b. _____ |

**HOSPITALIZATIONS:**

None

List Reason for Hospitalizations:

Dates:

Hospital / Facility:

- |          |          |          |
|----------|----------|----------|
| 1) _____ | a. _____ | b. _____ |
| 2) _____ | a. _____ | b. _____ |
| 3) _____ | a. _____ | b. _____ |

**CURRENT MEDICATIONS:**

None

List any prescriptions, drugs, and/or non-prescription medications, including vitamins, nutritional supplements, or anything taken orally. (Inform the nurse if you need help with this section)

List Names of Medications:

Dose or strength:

How often taken:

- |           |          |          |
|-----------|----------|----------|
| 1) _____  | a. _____ | b. _____ |
| 2) _____  | a. _____ | b. _____ |
| 3) _____  | a. _____ | b. _____ |
| 4) _____  | a. _____ | b. _____ |
| 5) _____  | a. _____ | b. _____ |
| 6) _____  | a. _____ | b. _____ |
| 7) _____  | a. _____ | b. _____ |
| 8) _____  | a. _____ | b. _____ |
| 9) _____  | a. _____ | b. _____ |
| 10) _____ | a. _____ | b. _____ |

**PHARMACY:** \_\_\_\_\_

**FEMALES ONLY:**

Age at onset of periods: \_\_\_\_\_ Periods are: HEAVY MEDIUM LIGHT Cycle\_\_\_\_Days  
Date of last period: \_\_\_\_\_ Birth Control Method: \_\_\_\_\_  
Number of full-term pregnancies: \_\_\_\_\_ Number of abortions or miscarriages: \_\_\_\_\_  
Cesarean Birth: YES NO Number of premature deliveries: \_\_\_\_\_ Number of living children: \_\_\_\_\_  
Abnormal Pap Test: YES NO

**REVIEW OF SYSTEMS:**

*Are you experiencing any of the following:*

**GENERAL**

- \_\_\_ Recent weight gain / loss
- \_\_\_ Fatigue
- \_\_\_ Loss of sleep
- \_\_\_ Change in appetite
- \_\_\_ Cancer (Type: \_\_\_\_\_)
- \_\_\_ Fevers, chills, sweats

**ENDOCRINE**

- \_\_\_ Hypothyroidism
- \_\_\_ Hyperthyroidism
- \_\_\_ Diabetes

**CARDIOVASCULAR**

- \_\_\_ Heart or chest pain
- \_\_\_ Chest pressure
- \_\_\_ High / low blood pressure
- \_\_\_ Pain down left arm
- \_\_\_ Irregular heartbeat
- \_\_\_ Swelling in legs

**MUSCULOSKELETAL**

- \_\_\_ Muscle aches
- \_\_\_ Joint pain / swelling
- \_\_\_ Back pain

**ALLERGIC / IMMUNOLOGIC**

- \_\_\_ Catch colds easily
- \_\_\_ Frequent sinus trouble
- \_\_\_ Kidney or bladder infection
- \_\_\_ Allergies

**FEMALES ONLY**

- \_\_\_ Irregular periods
- \_\_\_ Nipple discharge
- \_\_\_ Hot flashes
- \_\_\_ Menstrual cramps
- \_\_\_ Lump in breast

**SKIN**

- \_\_\_ Frequent rash
- \_\_\_ Change in mole
- \_\_\_ Frequent itching
- \_\_\_ Easy bruising

**EYES, EARS, NOSE & THROAT**

- \_\_\_ Vision problems
- \_\_\_ Glaucoma
- \_\_\_ Ear pain
- \_\_\_ Sore throat
- \_\_\_ Hearing loss
- \_\_\_ Mouth sores
- \_\_\_ Nose bleeds
- \_\_\_ Hoarseness
- \_\_\_ Nasal congestion
- \_\_\_ Difficulty swallowing

**GASTROINTESTINAL**

- \_\_\_ Abdominal pain
- \_\_\_ Constipation
- \_\_\_ Diarrhea
- \_\_\_ Indigestion or heartburn
- \_\_\_ Ulcers
- \_\_\_ Vomiting blood
- \_\_\_ Change in bowel habits

**HEALTHCARE MAINTENANCE**

Date of last physical exam: \_\_\_\_\_  
Date of last colonoscopy: \_\_\_\_\_  
Date of last bone density: \_\_\_\_\_  
Date of last lipid screen: \_\_\_\_\_  
Females only:  
Date of last pap test: \_\_\_\_\_  
Date of last mammogram: \_\_\_\_\_

**NEUROLOGICAL**

- \_\_\_ Light headed / dizziness
- \_\_\_ Fainting / blackouts
- \_\_\_ Weakness
- \_\_\_ Memory loss
- \_\_\_ Concussion
- \_\_\_ Numbness / tingling
- \_\_\_ Headaches / migraines
- \_\_\_ Difficulty with balance
- \_\_\_ Tremors
- \_\_\_ Epilepsy / Seizures

**RESPIRATORY / LUNGS**

- \_\_\_ Coughing
- \_\_\_ Coughing up blood
- \_\_\_ Shortness of breath
- \_\_\_ Asthma / emphysema
- \_\_\_ Tuberculosis

**GENITAL – URINARY**

- \_\_\_ Painful urination
- \_\_\_ Frequent urination
- \_\_\_ Burning with urination
- \_\_\_ Difficulty starting urine
- \_\_\_ Blood in urine
- \_\_\_ Sexual difficulty
- \_\_\_ Loss of libido
- \_\_\_ Kidney stones