Patient Health History

Date: _____/___/______

Name: ____ Date of Birth: _____/___/_____Age: _____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Sex: ❑ F ❑ M Height:_______ Weight :_______ Primary Language: _________________Do you need an interpreter? _____

Referred here by (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: ____

Primary Care Physician: __________________________ Internist: ____________________ Cardiologist: __________________

Have you had a recent medical evaluation by one of these doctors? _________ Name of Doctor: ___________________________

Past Medical History

In the past 4 weeks, have you had a cough, cold, sore throat or bronchitis that required treatment? ____________

Do you now or have you ever had any of the following? (if yes, check box)

☐ Cancer Type:_____________	☐ Anemia	☐ Jaundice	☐ Epilepsy
☐ Goiter	☐ Emphysema	☐ Pneumonia	☐ Rheumatic fever
☐ Cataracts	☐ Heart Problems	☐ HIV/AIDS	☐ Colitis
☐ Nervous Breakdown	☐ Leukemia	☐ Glaucoma	☐ Psoriasis
☐ Bad Headaches	☐ Diabetes	☐ Asthma	☐ Arthritis
☐ Kidney Disease	☐ Stomach Ulcers	☐ Stroke	☐ Childhood Arthritis
☐ High Blood Pressure	☐ Gout	☐ Tuberculosis	

List any other conditions you have had that are not already noted
____
____
____

Current Medications (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements)

Drug Allergies: Yes ________ No __________ To What? ____
Type of Reaction:____

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication?	Please check: Helped? A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

Have you used blood thinners, such as Coumadin, Heparin, Aspirin, Ibuprofen, Alleve, or Plavix, with in the past 2 weeks? ___________
Have you ever taken steroids, such as Prednisone or Medrol, by mouth? ____________ If yes, when and for how long? ____________
Do you take medication for Osteoporosis such as Fosamax, Actonel, or Boniva? ____
Date of last EKG_____/_____/______ Date of last Blood draw _____/____/______ Date of last Chest X-ray ____/___/____

Patient's Name ________________________________ Date Reviewed: ________________ Physician Initials ___________

List All Surgeries **Year** **Reason**

	Year	Reason
1.		
2.		
3.		
4.		
5.		

Social and Family History

Have you ever smoked? □ Yes □ No Quantity/Amount:_____________ If quit, how long ago? ________________________________
Do you drink alcohol? □ Yes □ No number per week ___________ Has anyone ever told you to cut down on your drinking? □ Yes □ No
Do you use recreational drugs, such as marijuana, cocaine, meth? □Yes □No If yes, please list__________________________________

Do you know of any blood relative who has or had any of the following? (check and indicate relationship)

□ Cancer ____________ Type_____________ □ Heart Disease _____________ □ Rheumatoid Arthritis ____________ □ Tuberculosis _________________
□ Leukemia __________ □ High Blood pressure ________ □ Osteoarthritis _________________ □ Diabetes ____________________
□ Stroke _____________ □ Bleeding tendency __________ □ Asthma ______________________ □ Goiter ______________________
□ Colitis _____________ □ Alcoholism ________________ □ Psoriasis _____________________ □ Autoimmune Disease __________

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

CONSTITUTIONAL

❑ Recent weight gain
amount ________
❑ Recent weight loss
amount _______
❑ Fatigue
❑ Weakness
❑ Fever

Eyes

☐ Loss of Vision
☐ Double or blurred Vision
❑ Itching eyes

EARS–NOSE–MOUTH–THROAT

❑ Bleeding gums
❑ Ringing in ears
❑ Loss of hearing
❑ Nosebleeds
❑ Runny nose
❑ Sores in mouth
❑ Loss of taste
❑ Dryness of mouth
❑ Frequent sore throats
❑ Difficulty in swallowing

CARDIOVASCULAR

❑ Pain in chest
❑ Heart murmurs
❑ Irregular heart beat
❑ Sudden changes in heart beat
❑ High blood pressure

MUSCULOSKELETAL

❑ Morning stiffness Lasting how long?
❑ Joint pain
❑ Muscle weakness
❑ Muscle tenderness
❑ Joint swelling
List joints affected in the last 6 mos.

GASTROINTESTINAL

❑ Nausea
❑ Vomiting of blood or coffee ground material
❑ Stomach pain relieved by food or milk
❑ Blood in stools
❑ Jaundice
❑ Persistent diarrhea
❑ Black stools
❑ Heartburn
☐ Increasing constipation

GENITOURINARY

☐ Difficult Urination
☐ Pain or burning on urination
❑ Rash/ulcers
❑ Blood in urine
❑ Pus in urine
❑ Cloudy, "smoky" urine
❑ Discharge from penis/vagina
❑ Getting up at night to pass urine
❑ Sexual difficulties
❑ Vaginal dryness

RESPIRATORY

❑ Shortness of breath
❑ Difficulty in breathing at night
❑ Wheezing (asthma)
❑ Swollen legs or feet
❑ Cough
☐ Coughing up blood

INTEGUMENTARY (SKIN AND/OR BREAST)

❑ Easy bruising
❑ Redness
❑ Rash
❑ Hives
❑ Hair loss
❑ Tightness
❑ Nodules/bumps
❑ Color changes of hands or feet in the cold

NEUROLOGICAL SYSTEM

❑Headaches
❑ Dizziness
❑ Night sweats
❑ Sensitivity or pain of hands and/or feet
❑ Memory loss
❑ Fainting
❑ Muscle spasm
❑ Loss of consciousness

HEMATOLOGIC/LYMPHATIC

☐ Transfusion? When
❑ Swollen glands
❑ Tender glands
❑ Anemia
❑ Bleeding tendency

PSYCHIATRIC

☐ Excessive worries
❑ Easily losing temper
☐ Anxiety
❑ Depression
❑ Difficulty falling asleep
❑ Difficulty staying asleep

ENDOCRINE

❑ Excessive thirst

ALLERGIC/IMMUNOLOGIC

❑ Frequent sneezing
❑ Increased susceptibility to infection

Patient's Name Date Reviewed: Physician Initials ___________