

## Health History Form

DATE: \_\_\_\_\_

NAME: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Gender:  M  F Birthdate: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

### Allergies:

#### Medication or Substance

#### Reaction

No Allergies

_____	_____
_____	_____
_____	_____

### Current Medications:

#### Label – Name

#### Dose

#### Frequency

OR

See Attached List

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Social History

Single  Married (their name: \_\_\_\_\_)  Domestic Partner (their name: \_\_\_\_\_) # Kids \_\_\_\_\_

Do you use tobacco products?  Daily  Some Days  Quit  Passive (around cigarette smoke)  Never  
Packs per Day \_\_\_\_\_ Years Smoked \_\_\_\_\_ Date Quit \_\_\_\_\_

Type(s) of Tobacco:  Cigarettes  Cigars  E-Cigarettes  Chew  Snuff

Do you drink alcohol?  Yes  No  Quit Date Quit \_\_\_\_\_

Drinks per Day \_\_\_\_\_ Drinks per Week \_\_\_\_\_ Type:  Beer  Wine  Liquor

Do you use recreational drugs?  Never  Yes – Use per Week \_\_\_\_\_  No  Quit Date Quit \_\_\_\_\_

Have you ever used injected/IV drugs?  Yes  No

Types:  Cocaine  Marijuana  Methamphetamines  Stimulants  Heroin

Depressants  Hallucinogens (LSD, mushrooms)  Opioids (vicodin, oxycodone)

Are you sexually active?  Yes  No Partners:  Male  Female Birth Control: \_\_\_\_\_

Are you working?  Yes What do you do? \_\_\_\_\_  No  Retired  Disabled

### Medical History

Please check box for those conditions you have now or have ever had

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> No Past Medical History    | <input type="checkbox"/> Congestive Heart Failure       | <input type="checkbox"/> Gynecologic Problem         | <input type="checkbox"/> Muscle or Joint Pain      |
| <input type="checkbox"/> Allergies                  | <input type="checkbox"/> COPD/Emphysema                 | <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Heart Attack              |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Heart Disease                  | <input type="checkbox"/> Hepatitis or Liver Problems | <input type="checkbox"/> Osteoporosis (Thin Bones) |
| <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Depression                     | <input type="checkbox"/> HIV/AIDS                    | <input type="checkbox"/> PPD                       |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Diabetes Type 1                | <input type="checkbox"/> Hypertension/High BP        | <input type="checkbox"/> Seizures or Epilepsy      |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Diabetes Type 2                | <input type="checkbox"/> Insomnia / Sleep Problems   | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Bleeding/Clotting Problems | <input type="checkbox"/> Gastric Ulcer / Stomach Ulcer  | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Substance / Drug Abuse    |
| <input type="checkbox"/> Blood Transfusion          | <input type="checkbox"/> GERD (Acid Reflux, Heart Burn) | <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Thyroid Disease           |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Glaucoma                       | <input type="checkbox"/> Migraine                    | <input type="checkbox"/> Tuberculosis              |

Other (Please list): \_\_\_\_\_

## Surgical History

Please check box for any surgery you have had, indicate the year

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> No Past Surgical History     | <input type="checkbox"/> Cataract Removal/IOL Implant (_____)   | <input type="checkbox"/> Pacemaker/Defibrillator (_____)  |
| <input type="checkbox"/> Appendix Removal (_____)     | <input type="checkbox"/> Gall Bladder Surgery (_____)           | <input type="checkbox"/> Splenectomy (_____)              |
| <input type="checkbox"/> Back Surgery (_____)         | <input type="checkbox"/> Colonoscopy (_____)                    | <input type="checkbox"/> Thyroid Surgery (_____)          |
| <input type="checkbox"/> Blood Transfusion (_____)    | <input type="checkbox"/> Colposcopy (_____)                     | <input type="checkbox"/> Tonsillectomy (_____)            |
| <input type="checkbox"/> Breast Surgery (_____)       | <input type="checkbox"/> Abdominal Surgery (_____)              | <input type="checkbox"/> Tubal Ligation (_____)           |
| <input type="checkbox"/> C-Section (_____)            | <input type="checkbox"/> Hernia Repair (_____)                  | <input type="checkbox"/> Ear Surgery (_____)              |
| <input type="checkbox"/> Heart Bypass Surgery (_____) | <input type="checkbox"/> Hysterectomy or Uterus Removal (_____) | <input type="checkbox"/> Valve Replacement/Repair (_____) |
| <input type="checkbox"/> Cancer Surgery (_____)       | <input type="checkbox"/> Joint Replacement (_____)              | <input type="checkbox"/> Weight Loss Surgery (_____)      |

Other (Please list): \_\_\_\_\_

## Family History—Check all that apply

Relationship	First Name	Status (circle)	No Known Problems	Arthritis	Asthma	Birth Defects	Cancer	Clotting Disorder	Depression	Diabetes	Early Sudden Death	Hearing Loss	Heart Disease	Hypertension	Kidney Problems	Mental Illness	Stroke	Substance /Drug Abuse	Vision Loss	Other:	
																					alive
Mother		alive																			
Father		alive																			
Maternal Grandmother		alive																			
Maternal Grandfather		alive																			
Paternal Grandmother		alive																			
Paternal Grandfather		alive																			
Brother		alive																			
Sister		alive																			
Maternal Aunt		alive																			
Maternal Uncle		alive																			
Paternal Aunt		alive																			
Paternal Uncle		alive																			
Other:		alive																			

**\*\*Type of Cancer or Disease:** \_\_\_\_\_

## Screening

In the past two weeks, how often have you been bothered by the following? (Please circle one response per statement.)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

Have you fallen in the past year?  Yes  No  
Are you afraid of falling?  Yes  No

Do you have issues with balance or feeling unsteady?  Yes  No  
Do you feel safe at home?  Yes  No

## Health Maintenance

		<b>Yes</b>	<b>No</b>		
Women	Menstrual Period	<input type="checkbox"/>	<input type="checkbox"/>	Last _____	# of pregnancies _____ # deliveries _____
				Menstrual Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
				Vaginal Discharge:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
				Irritation or Abnormal Bleeding:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
	Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>	When _____	Abnormal? _____
	Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	When _____	Abnormal? _____
General	Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	When _____	Where _____
	Dexa/Bone Density	<input type="checkbox"/>	<input type="checkbox"/>	When _____	Where _____
	Eye Exam	<input type="checkbox"/>	<input type="checkbox"/>	When _____	Where _____
	Dental Exam	<input type="checkbox"/>	<input type="checkbox"/>	When _____	Where _____

## Immunizations

Tetanus or TDAP	<input type="checkbox"/>	<input type="checkbox"/>	When _____	Where _____
Flu	<input type="checkbox"/>	<input type="checkbox"/>	When _____	Where _____
Pneumovax	<input type="checkbox"/>	<input type="checkbox"/>	When _____	Where _____
Prevnar	<input type="checkbox"/>	<input type="checkbox"/>	When _____	Where _____
Zostavax (Shingles)	<input type="checkbox"/>	<input type="checkbox"/>	When _____	Where _____

## Review of Systems (current symptoms) – please check only if these are bothering you at this time

### Gastrointestinal

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Nausea             | <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Stomach Pain  | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Vomiting Blood     | <input type="checkbox"/> Black Tarry Stools    | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> Diarrhea      | <input type="checkbox"/> Abdominal Swelling | <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> Other: _____          | <input type="checkbox"/> Other: _____    |

### Constitutional

- |                                      |                                      |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Fevers      | <input type="checkbox"/> Fatigue     |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss |

### Head / Eyes

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Cataracts   | <input type="checkbox"/> Dry Eyes        |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Color Blindness |

### Ears/Nose/Mouth/Throat

- |  |   |
|--|---|
| <input type="checkbox"/> Hearing Loss  | <input type="checkbox"/> Chronic Sinus Congestion |
| <input type="checkbox"/> Heavy Snoring | <input type="checkbox"/> Bad Teeth                |

### Respiratory (lungs)

- |  |   |
|--|---|
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Asthma           |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Emphysema (COPD) |

### Heart

- |   |  |
|---|--|
| <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Palpitations        |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> High Blood Pressure |

### Genitourinary

- |  |   |
|--|---|
| <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Burning with Urination |
| <input type="checkbox"/> Blood in Urine  | <input type="checkbox"/> Leakage of Urine       |

### Muscles/Bones

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Chronic Pain    | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Bone Pain  |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Muscle Cramping | <input type="checkbox"/> Joint Pain |

### Skin

- |                                  |                                    |
|----------------------------------|------------------------------------|
| <input type="checkbox"/> Rash    | <input type="checkbox"/> Jaundice  |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Psoriasis |

### Neurological

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures (Epilepsy) |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Tremor (shaking)    |

### Vascular

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Varicose Veins |
|--------------------------------------|---|

### Psychosocial

- |   |   |  |  |                                      |
|---|---|--|--|--------------------------------------|
| <input type="checkbox"/> Anxiety / Nerves | <input type="checkbox"/> Abusive Relationship | <input type="checkbox"/> Sexual Problems       | <input type="checkbox"/> Sleep Problems      | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Feeling Worthless    | <input type="checkbox"/> Want to Hurt Yourself | <input type="checkbox"/> Want to Hurt Others | <input type="checkbox"/> Drug Use    |

### Endocrine

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Bothered by Heat |
| <input type="checkbox"/> High Thirst | <input type="checkbox"/> Bothered by Cold |

### Blood / Lymph

- |  |  |
|--|--|
| <input type="checkbox"/> Swollen Lymph Nodes |  |
| <input type="checkbox"/> Easy Bruising       | <input type="checkbox"/> Easy Bleeding |