Patient Health History

Today's Date: _____

Patient's Last Name: _____ First: _____ Middle Initial: _____

Date of Birth: _____

Primary Care Physician (First & Last name): _____

Location: _____

Employer: _____

Occupation: _____

REASON FOR VISIT: _____ **Date of Illness/Injury:** _____

FOR PATIENTS THAT ARE 65 YEARS OF AGE AND OLDER

Did you fall in the past year? ☐Yes ☐No How many times? _____ Did the fall(s) result in an injury? ☐Yes ☐No

Do you use a walking aid or has one been recommended? ☐Yes ☐No ☐N/A Details: _____

REVIEW OF SYSTEMS:

Are you **CURRENTLY** experiencing any of the following?

CONSTITUTIONAL ☐Normal

No	Yes	
☐	☐	Chills
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Malaise
☐	☐	Night sweats
☐	☐	Weakness
☐	☐	Weight gain
☐	☐	Weight loss

HEENT ☐Normal

No	Yes	
☐	☐	Blurred vision
☐	☐	Double vision
☐	☐	Dysphagia
☐	☐	Ear drainage
☐	☐	Facial pain
☐	☐	Headache
☐	☐	Hearing loss
☐	☐	Hoarseness
☐	☐	Nasal congestion
☐	☐	Ringing in ears
☐	☐	Vertigo
☐	☐	Vision loss

RESPIRATORY ☐Normal

No	Yes	
☐	☐	Chest pain *(respiratory)*
☐	☐	Cough
☐	☐	Dyspnea / Shortness of Breath
☐	☐	Recent infections
☐	☐	Known TB exposure
☐	☐	Wheezing

CARDIOVASCULAR ☐Normal

No	Yes	
☐	☐	Chest pain
☐	☐	Cyanosis
☐	☐	Heart murmur
☐	☐	Leg swelling
☐	☐	Syncope
☐	☐	Irregular heartbeat/ palpitations
☐	☐	Thrombophlebitis

GASTROINTESTINAL ☐Normal

No	Yes	
☐	☐	Abdominal pain
☐	☐	Constipation
☐	☐	Black tarry stools
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Jaundice
☐	☐	Loss of appetite
☐	☐	Nausea
☐	☐	Vomiting

GENITOURINARY ☐Normal

No	Yes	
☐	☐	Dysuria
☐	☐	Frequent urination
☐	☐	Hematuria
☐	☐	Urge incontinence
☐	☐	Urinary incontinence

METABOLIC/ENDOCRINE ☐Normal

No	Yes	
☐	☐	Cold intolerant
☐	☐	Hair loss
☐	☐	Heat intolerant

NEUROLOGICAL ☐Normal

No	Yes	
☐	☐	Difficulty walking
☐	☐	Dizziness
☐	☐	Poor coordination
☐	☐	Memory loss
☐	☐	Muscle weakness
☐	☐	Paresthesia
☐	☐	Seizures
☐	☐	Tremors

PSYCHIATRIC

No	Yes	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Insomnia

INTEGUMENTARY ☐Normal

No	Yes	
☐	☐	Contact allergy
☐	☐	Itchy skin
☐	☐	Rash
☐	☐	Skin infections
☐	☐	Skin lesion

MUSCULOSKELETAL

☐ **Negative, except as noted in HPI and chief complaint**

Hematologic ☐Normal

No	Yes	
☐	☐	Bleeding
☐	☐	Bruising
☐	☐	Pulmonary embolus
☐	☐	DVT

IMMUNOLOGICAL ☐Normal

No	Yes	
☐	☐	Asthma
☐	☐	Bee sting allergies
☐	☐	Contact dermatitis
☐	☐	Environmental allergies
☐	☐	Food allergies
☐	☐	Seasonal allergies

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FAMILY HISTORY - Check the boxes below if any **blood** relative has been diagnosed with any of the following:

	Relationship		Relationship
☐ Anesthesia problems	_____	☐ Osteoporosis	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding/clotting problems	_____	☐ Family history unknown	
☐ Cancer: type: _____	_____	☐ No significant family history	

SOCIAL HISTORY

HAND DOMINANCE
☐ Right
☐ Left
☐ Ambidextrous

DO YOU DRINK ALCOHOL?
☐ Yes
☐ No
What kind & how much?
_____
_____

DO YOU USE TOBACCO?
☐ Yes
Type of tobacco: _____
☐ No
☐ Former
Type of tobacco: _____
Age quit: _____

CURRENT/FORMER ILLICIT DRUG USE
☐ None
☐ Current
What kind? _____
☐ Former
What kind? _____
Date quit: _____

MEDICATIONS- Please list any medication(s) you are currently taking, include prescribed medications, vitamins, supplements and over-the-counter medications

Medication	Dosage/Directions	Problem being treated	Prescribing doctor

☐ MEDICATION LIST COPIED. SEE ATTACHED MEDICATION LIST.

Pharmacy Preference (include location): _____

Are you being treated by pain management? ☐Yes ☐No If so, where? _____

ALLERGIES:

Are you allergic to?: ☐Aspirin ☐Penicillin ☐Codeine ☐Sulfa ☐Latex ☐Betadine ☐Tape ☐IVP dye

☐ Iodine/shellfish ☐Eggs, Birds/Feathers ☐Other ☐ I HAVE **NO KNOWN ALLERGIES**

☐ Reaction: _____

CURRENT TREATING PHYSICIANS:

Cardiologist: _____ Pulmonologist: _____ Neurologist: _____

Endocrinologist: _____ Hematologist: _____ Other: _____

_____ _____ _____

Patient / Guardian Signature DOB Date

PAST MEDICAL HISTORY- Check all conditions you have now, or have had in the past.

CANCER
- ☐ Type: _____

CARDIOVASCULAR (heart & blood vessels)
- ☐ Angina (chest pain)
- ☐ Arrhythmia/Irregular heartbeat
- ☐ Blood clot/DVT (deep vein thrombosis)
  Date Occurred: _____
- ☐ Heart Attack/MI
- ☐ Heart disease/Coronary Artery disease
- ☐ High Cholesterol/Hyperlipidemia
- ☐ MVP (mitral valve prolapse)
- ☐ Pacemaker: year _____
- ☐ Varicose veins/Peripheral Vascular disease
- ☐ Hypertension/High blood pressure
- ☐ Stent - Date Occurred: _____
- ☐ AICD (Automatic Implantable Cardioverter Defibrillator)

PULMONARY/RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ PE (pulmonary embolism/blood clot in lung)
  Date Occurred: _____
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Sleep Apnea
  - ☐ Currently uses a C-PAP machine
- ☐ TB (tuberculosis)

GENITOURINARY (kidneys & urinary tract)
- ☐ Renal failure
- ☐ Renal insufficiency
- ☐ UTI (urinary tract infection)
- ☐ Currently pregnant

GASTROINTESTINAL (stomach & digestive)
- ☐ Colon Polyps
- ☐ Gastric Ulcer
- ☐ GERD
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hepatitis - type unknown
- ☐ Hernia
- ☐ Irritable Bowel
- ☐ Stomach Ulcer
- ☐ Liver Disease/Cirrhosis
- ☐ Reflux

BONES JOINTS & MUSCLES
- ☐ Arthritis
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoporosis
- ☐ Scoliosis

PSYCHIATRIC DISORDER (mental health)
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Drug/Alcohol Abuse
- ☐ Suicidal thoughts

HEENT (head, ears, eyes, nose & throat)
- ☐ Blind
- ☐ Deaf
- ☐ Hearing loss

NEUROLOGIC DISORDER (brain & nervous sys)
- ☐ Alzheimer's disease
- ☐ Dementia
- ☐ MS (Multiple Sclerosis)
- ☐ Parkinson's disease
- ☐ Seizure Disorder
- ☐ Stroke/CVA/TIA - Date Occurred: _____
- ☐ Myasthenia gravis
- ☐ Muscular dystrophy
- ☐ Migraines

HEMATOLOGIC (blood & lymph node)
- ☐ Anemia
- ☐ Edema
- ☐ Lupus
- ☐ Hemophilia
- ☐ Sickle cell disease
- ☐ Clotting Disorders

ENDOCRINE (hormones & metabolic)
- ☐ Diabetes - Type I
- ☐ Diabetes - Type II
- ☐ Diabetes - Type unknown
- ☐ Thyroid dysfunction
  - ☐ Hypothyroidism
  - ☐ Hyperthyroidism
- ☐ Hemoglobin A1C _____

IMMUNE / AUTOIMMUNE & INFECTIOUS PROBLEMS
- ☐ AIDS
- ☐ HIV positive
- ☐ Rheumatoid Arthritis
- ☐ MRSA (Methicillin Resistant Staph Aureus)
- ☐ Autoimmune Disorder

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: _____

_____

PAST SURGICAL HISTORY - Check all that apply and indicated which side R/L as appropriate

- ☐ ACL surgery: year _____ R/L
- ☐ Aneurysm: year _____
- ☐ Angioplasty: year _____
- ☐ Angio w/stent: year _____
- ☐ Appendectomy: year _____
- ☐ Arthroscopy ankle: year _____ R/L
- ☐ Arthroscopy elbow: year _____ R/L
- ☐ Arthroscopy hip: year _____ R/L
- ☐ Arthroscopy knee: year _____ R/L
- ☐ Arthroscopy wrist: year _____ R/L
- ☐ Arthroscopy shoulder: year _____ R/L
- ☐ Back surgery: year _____
- ☐ Cardiac/Heart Surgery: year _____
- ☐ Carpal tunnel release: year _____ R/L
- ☐ Cataract extraction: year _____
- ☐ Colectomy: year _____
- ☐ Colostomy: year _____
- ☐ Fracture: year _____
- ☐ Gallbladder: year _____
- ☐ Gastric bypass: year _____
- ☐ Hernia repair: year _____
- ☐ Hip replacement: year _____ R/L
- ☐ Knee replacement: year _____ R/L
- ☐ Laminectomy: year _____
- ☐ Meniscus surgery: year _____ R/L
- ☐ Pacemaker: year _____
- ☐ Prostate: year _____
- ☐ Rotator cuff repair: year _____ R/L
- ☐ Small bowel resection: year _____
- ☐ Thyroidectomy: year _____
- ☐ Transplant: _____

☐ Mastectomy: year _____ ☐ Hysterectomy: year _____

☐ OTHER SURGERIES NOT LISTED ABOVE: _____

☐ PROBLEMS WITH PAST ANESTHESIA (IF YES, PLEASE LIST): _____

☐ CURRENTLY BEING TREATED WITH: ☐ Dialysis ☐ Chemotherapy ☐ Radiation ☐ Oxygen (Day/Night) _____# of liters