Patient Health History

Patient's Name: ___________________________ **Date of Birth:** ______________ **Age:** ________ **Male / Female**

Current Medical Provider: ________________________________ Reason for transfering care: ____________________________

CURRENT HEALTH

Present Health Concerns: ____

MEDICATIONS: Please list ALL medications including Vitamins, herbs, home remedies (list additional on back of page)

Medication Name	Strength (mg)	Directions	Reason Taking
Aspirin Yes No			
Fish Oil Yes No			

ALLERGIES: or reactions to Medications, environmental, animals, food, vaccines, etc. (list additional on back of page)

Allergy	Symptoms or reaction

HEALTH SCREENING QUESTIONNAIRE:

Do you now or have you ever used tobacco? ○ Current ○ Previous ○ Never

How many times in the past year have you had 4 or more drinks in a day? ○ None ○ 1 or more

One Drink = 12 oz. beer 5 oz. wine 1.5 oz. liquor (1 shot)

Do you sometimes use drugs recreationally, including marijuana without a medical marijuana card, or prescription drugs more than they are prescribed for or just for the way they make you feel? ○ None ○ 1 or more

In the last 2 weeks have you been bothered by: A): Little interest or pleasure in doing things? ○ No ○ Yes

B): Feeling down, depressed or hopeless? ○ No ○ Yes

Patient's Name: ____ Date of Birth: ___________________________

MEDICAL HISTORY

Please indicate with an **X** all that apply:

- [ ] Brain Cancer
- [ ] Breast Cancer
- [ ] Colon Cancer
- [ ] Leukemia
- [ ] Lung Cancer
- [ ] Lymphoma
- [ ] Ovarian Cancer
- [ ] Pancreatic Cancer
- [ ] Prostate Cancer
- [ ] Skin Cancer
- [ ] Tumor (benign)
- [ ] Tumor (malignant)
- [ ] Other Cancer __________

- [ ] CHF
- [ ] DVT
- [ ] High Cholesterol
- [ ] High Blood Pressure
- [ ] MI (Heart Attack)
- [ ] Stroke
- [ ] Atrial Fibrillation

- [ ] Eye Disease
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Otitis Media (ear infections)
- [ ] Cataracts

- [ ] Dysplastic Moles

- [ ] Arthritis
- [ ] Chronic Back Pain
- [ ] Fibromyalgia
- [ ] Fractures
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Rheumatoid Arthritis

- [ ] Autoimmune Disorder
- [ ] Diabetes Type I
- [ ] Diabetes Type II
- [ ] Endocrine Issues
- [ ] Hyperthyroidism (high)
- [ ] Hypothyroidism (low)

- [ ] Asthma
- [ ] COPD
- [ ] Pneumonia
- [ ] Pulmonary Embolism
- [ ] Sleep Apnea
- [ ] TB (Tuberculosis)

- [ ] Chronic Headaches
- [ ] Epilepsy
- [ ] Migraines
- [ ] Neurological Disorder
- [ ] Seuzure Disorder

- [ ] Anxiety Disorder
- [ ] BiPolar
- [ ] Dementia
- [ ] Depression
- [ ] Development Disorder
- [ ] Psychiatric Illness
- [ ] Substance Abuse
- [ ] Suicide Attempt

- [ ] Diverticulitis
- [ ] Diverticulosis
- [ ] GERD
- [ ] GI Bleed
- [ ] Hepatits ________
- [ ] Liver Disease
- [ ] Ulcer
- [ ] Ulcerative Colitis

- [ ] Kidney Disease
- [ ] Kidney Failure
- [ ] Kidney Stones
- [ ] Urinary Disorder

- [ ] Anemia
- [ ] Bleeding Disorders
- [ ] Blood Transfusions
- [ ] Clotting Disorders
- [ ] Peripheral Vascular Disease

- [ ] MRSA

- [ ] Other:

SURGICAL HISTORY

Please indicate with an **X** all that apply:

- [ ] Hernia Repair
- [ ] Gallbladder Removed
- [ ] Gastric Surgery
- [ ] Small Bowel Resection
- [ ] Colon Resection
- [ ] Appendix Removed
- [ ] Breast Lumpectomy
- [ ] Mastectomy
- [ ] Breast Augmentation

- [ ] Coronary Artery Bypass
- [ ] Coronary Artery Stenting
- [ ] Heart Valve Surgery

- [ ] Other:

- [ ] Peripheral Vascular Bypass
- [ ] Peripheral Vascular Stenting
- [ ] Aneurysm Repair
- [ ] Carotid Surgery
- [ ] Vein Surgery

- [ ] Lung Surgery
- [ ] Esophageal Surgery

- [ ] Bunion Surgery
- [ ] Hammer Toe Correction

- [ ] Repair Up Extremity Fracture
- [ ] Repair Low Extremity Fracture
- [ ] Arthroscopy

- [ ] Rotator Cuff Repair R / L
- [ ] ACL Repair
- [ ] Total Hip Replacement R / L
- [ ] Total Knee Replacement R / L
- [ ] Total Shoulder Replacement
- [ ] Carpal Tunnel Surgery R / L

- [ ] Prostate Surgery- Cancer
- [ ] Prostate Surgery for BPH
- [ ] Incontinence Surgery
- [ ] Kidney Removed
- [ ] Bladder Surgery

- [ ] Tonsillectomy
- [ ] Ear Tube Placement

- [ ] Hysterectomy
- [ ] Ovary Removed R / L
- [ ] C-Section
- [ ] Laparoscopy
- [ ] Bladder Suspension

- [ ] Cervical Surgery
- [ ] Lumbar Surgery
- [ ] Thoracic Spine Surgery

- [ ] Cataract Surgery
- [ ] Eyelid Surgery

- [ ] Craniotomy

SOCIAL HISTORY

Occupation: ________________________ Where Employed: _______________________ Education Level: __________________________

Lives With: _________________________ Marital Status: ____________________ Spouse's Name: ________________________________

# of Children: ________ Nickname: ___________________ Religion: ______________________ Primary Language: ___________________

Patient's Name: ____ Date of Birth: ______________________

FAMILY HEALTH HISTORY

Please indicate with an **X** family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Mom's Sister	Mom's Brother	Dad's Mom	Dad's Dad	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Angina												
Arthritis												
Anxiety												
Asthma												
Birth Defects												
Bleeding Disease												
Breast Cancer												
Cervical Cancer												
Coronary Heart Disease												
Colon Cancer												
Depression												
Diabetes												
Growth / Development Disorder												
Headaches												
Heart Disease												
Hypertension												
High Cholesterol												
Kidney Disease												
Lung Cancer												
Lung / Respiratory Disease												
Melanoma / Skin Cancer												
Migraines												
Osteoporosis												
Ovarian Cancer												
Psychiatric Care												
Seizures												
Severe Allergies												
Stroke												
Thyroid Problems												
Uterine Cancer												
Weight Disorder												
Other Cancer												
Other Medical Problems												

No / Unknown Family History ☐

TOBACCO USE

Current tobacco use: O Never O Former O Currently - how much per day: _________ O Cigg O Cigar O Pipe O E-cigg

Have you tried to quit? O No O Yes Method attempted: _______________ Passive smoke exposure? O No O Yes

ALCOHOL USE

Current alcohol use: O Never O Previous O Current - Average # drinks per day: ______ Type of alcohol: ___________

Have you ever been in treatment for an alcohol problem? O Never O Currently O In the past

SUBSTANCE USE

Do you use: O None O methamphetamines O cannabis O inhalants O tranquilizers O cocaine O narcotics O hallucinogens O other: ___________ How often used? O Daily O Weekly O Monthly

Reason for use:____

Patient's Name: ____ Date of Birth: ______________________

OTHER

Current caffeine use: _____ cups /day Type: O Coffee O Soda O Tea O Energy drinks O Other: _______________	
Exercise routinely? O Yes O No How many times per week? ______________ Type of exercise: ____________________	
Vehicle seatbelt use: O 100% O 75% O 50% O 25% O Never	
Sunshine exposure: O Frequently O Occassionally O Rarely Do you use sunscreen? O Yes O No	
Do you believe that you are at high risk for HIV? O No O Yes - Explain if so: ______________________________	

PREVENTATIVE CARE SCREENINGS

Please place an **X** next to each test and provide approximate date, results and place where it was done:

	Pap Smear Date: __________________ Results: O Normal O Abnormal Place: _____________________________
	Colon Screening: Type: O Colonoscopy O Sigmoidoscopy O Stool Hemoccult Date: ________________________ Results: O Normal O Abnormal # of polyps removed ______ Place: ___________________________
	Breast Screening Date: ________________ Results: O Normal O Abnormal Place: ___________________________
	Dexa Scan (bone density): Date: ______________ Results: O Normal O Abnormal Place: ______________________
	PSA (prostate level) Date: ______________ Results: O Normal O Abnormal

Please bring immunization/vaccine history information with you!

WOMEN'S HEALTH

Are you now or are you planning to become pregnant in the next year? O Currently Pregnant O No O Yes

Please place an **X** next to each option that applies:

	Hysterectomy		Depo - DMPA - Date of last shot: _______________
	Bilateral Tubal Ligation - Date: __________________		Condoms
	Hysteroscopic Tubal Occlusion - Date: ______________		Rhythm Method
	Implant/Nexplanon - Date: ____________________		Abstinence
	IUD Type: O Mirena O Paragard O Skyla - Date: ___________		Menopause Natural - Date: _________________
	Diaphram		Menopause Surgical - Date: _________________
	Oral/Hormonal Contraceptives: O Oral O Patch O Ring		Vasectomy

Age Menses Started: _________ Age Menopause Started: _________ Are you sexually active?: O Yes O No

Pregnancy History

Total pregnancies: ________ Deliveries: _________ Abortions: _________ Miscarriages: __________

ADVANCED DIRECTIVES IN PLACE

O None O Living Will O Durable Power of Attorney O Health Care Proxy O POLST

For office use only:

Reviewed by Provider: ____ **Date:** ___________________________

Records requested for screenings by: ______________________________________ Date: ___________________________