Patient Health History Form

Name ______________________________________ DOB__________________ Today's date ______________________

SSN ______________________ Allergies____

Previous PCP_______________________________ Specialists ____

Behavioral Health Providers ____

Current Medical Condition: What is the reason for your your visit today?

____

____

Past Medical History: Please check all that apply to you

- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Lung disease (asthma, COPD)
- ☐ Psychiatric disease
- ☐ Stroke
- ☐ Thyroid
- ☐ None

Previous Surgeries: Please list past surgeries with approximate date

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Serious Injuries: Please describe any serious injuries you have had

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____

Medications: Please list all medications you are taking with dose and frequency

Drug	***Dose/Frequency***

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Social:

Who do you live with? ___________________________ Do you have children? Yes No How Many?______

Women indicate the number of the following: Pregnancies ___ Live births ___ Miscarriages ___ Terminations ___

Do you drink alcohol? Yes No If yes, how much/week? ____

Do you smoke? Yes No If yes, how many cigarettes/day? ____

Do you consume caffeine? Yes No If yes, how many cups/week? _______________________________________

Do you use recreation drugs? Yes No If yes, please describe ____

Family History: Do you know of any blood relative that has been diagnosed with any of the following:

	Father	Mother	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather	Son	Daughter
Living status	☐ Alive ☐ Deceased Age at death____	☐ Alive ☐ Deceased Age at death____	☐ Alive ☐ Deceased Age at death____	☐ Alive ☐ Deceased Age at death____	☐ Alive ☐ Deceased Age at death____	☐ Alive ☐ Deceased Age at death____	☐ Alive ☐ Deceased Age at death____	☐ Alive ☐ Deceased Age at death____
Cancer, list type								
Diabetes, indicate type I, type II, or gestational								
Heart problems								
High blood pressure								
Kidney disease								
Lung disease (asthma, COPD)								
Psychiatric Disease								
Stroke								

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Name____________________________________ DOB________________________

Review the following list and check any problems or condition that you are experiencing now or have experienced in the past. If you do not have any problems listed in the section, please check none

General Health
- ☐ Good general health
- ☐ Recent weight change
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Fever/chills

Allergy
- ☐ Drug allergies
- ☐ Food allergies
- ☐ Hay fever
- ☐ Other: ____________________
- ☐ None

Ears, Nose, Mouth, Throat
- ☐ Difficulty swallowing
- ☐ Earaches
- ☐ Loss of hearing/deafness
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Painful chewing
- ☐ Ringing in ears
- ☐ Sinus infection
- ☐ Sores in mouth
- ☐ Other: ____________________
- ☐ None

Eyes
- ☐ Blind spots
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Glaucoma
- ☐ Injury
- ☐ Pain
- ☐ Other: ____________________
- ☐ None

Gastrointestinal
- ☐ Blood in stools
- ☐ Increasing constipation
- ☐ Nausea
- ☐ Painful bowel movements
- ☐ Persistent diarrhea
- ☐ Stomach or abdominal pain
- ☐ Ulcer
- ☐ Vomiting
- ☐ Other: ____________________
- ☐ None

Genitourinary
- ☐ Blood in urine
- ☐ Female: irregular periods
- ☐ Female: vaginal discharge
- ☐ Kidney stones
- ☐ Male: prostate disease
- ☐ Male: testicle pain
- ☐ Painful or burning urination
- ☐ Sexual difficulty
- ☐ Sexually transmitted disease
- ☐ Urgency with urination
- ☐ Urine retention/incontinence
- ☐ Other: ____________________
- ☐ None

Heart and Lungs
- ☐ Pain in chest
- ☐ Heart attack
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Other: ____________________
- ☐ None

Muscles/Joints/Bones
- ☐ Back pain
- ☐ Difficulty walking
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Muscle pain or tenderness
- ☐ Neck pain
- ☐ Other: ____________________
- ☐ None

Neurological
- ☐ Balance trouble
- ☐ Black outs/loss of consciousness
- ☐ Difficulty speaking
- ☐ Difficulty walking
- ☐ Facial drooping
- ☐ Headaches
- ☐ Injury to the brain or spine
- ☐ Light-headed or dizziness
- ☐ Memory loss
- ☐ Mental confusion
- ☐ Migraines
- ☐ Mini stroke
- ☐ Neuropathy
- ☐ Numbness or tingling
- ☐ Paralysis
- ☐ Stroke
- ☐ Tremors
- ☐ Weakness
- ☐ Other: ____________________
- ☐ None

Are you:
- ☐ Right handed
- ☐ Left handed
- ☐ Both

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Other: ____________________
- ☐ None

Pulmonary
- ☐ Asthma
- ☐ Blood in cough
- ☐ Cancer
- ☐ Chronic or frequent cough
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Other: ____________________
- ☐ None

Skin
- ☐ Rash or itching
- ☐ Sun sensitivity
- ☐ Hair loss
- ☐ Color changes
- ☐ Other: ____________________
- ☐ None

Sleep
- ☐ Snoring
- ☐ Sleepwalking
- ☐ Nightmares

Do you sleep well? ☐ Yes ☐ No

Do you feel rested when you wake?
☐ Yes ☐ No

Do you fall asleep during the day?
☐ Yes ☐ No