

# Health History

## *New Patient*

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

MR#: \_\_\_\_\_

Thank you for choosing our clinic for your healthcare needs! We appreciate your assistance with completing this form as it will help us better care for you. This is confidential information, and will be kept in your electronic medical record.

Were you referred by another physician? If so, who?

\_\_\_\_\_

Please describe the reason for your visit today. Please include the date of onset and any symptoms associated with the problem.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Medications**

Medication name	Dose and frequency	Need Refill (Y/N)?

Are you taking the medications as prescribed (Y/N)? \_\_\_\_

If not please explain. \_\_\_\_\_

\_\_\_\_\_

### **Allergies** (foods and drugs)

Please indicate type of reaction next to each.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Advanced Directives**

Do you have Advanced Directives? (such as living will, power of attorney, etc.) Yes\_\_ No\_\_  
 If yes, please specify.

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**Past Medical History/Problems** (check all that apply)

- |                                              |                                                     |                                                      |                                                   |
|----------------------------------------------|-----------------------------------------------------|------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Abnormal Pap Smear  | <input type="checkbox"/> Depression                 | <input type="checkbox"/> Hepatitis B                 |                                                   |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Diabetes, Gestational      | <input type="checkbox"/> Hepatitis C                 |                                                   |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Diabetes Type 1            | <input type="checkbox"/> Hypertension                |                                                   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes Type 2            | <input type="checkbox"/> Hyperthyroidism             | <input type="checkbox"/> Substance Abuse          |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Diverticulosis             | <input type="checkbox"/> Hypothyroidism              | <input type="checkbox"/> Thyroid Disorder         |
| <input type="checkbox"/> Bipolar Disorder    | <input type="checkbox"/> DVT                        | <input type="checkbox"/> Kidney Stone                | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Blood Transfusion   | <input type="checkbox"/> Dyslipidemia               | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> UTI - recurrent          |
| <input type="checkbox"/> Breast Ca.          | <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Varicose Veins/Phlebitis |
| <input type="checkbox"/> Cervical Ca.        | <input type="checkbox"/> GERD                       | <input type="checkbox"/> Osteoarthritis              | <input type="checkbox"/> NO MEDICAL PROBLEMS      |
| <input type="checkbox"/> Chronic Back Pain   | <input type="checkbox"/> Gout                       | <input type="checkbox"/> Osteoporosis                |                                                   |
| <input type="checkbox"/> Colon Cancer        | <input type="checkbox"/> GI Bleed (upper/lower)     | <input type="checkbox"/> Peptic Ulcer Disease        |                                                   |
| <input type="checkbox"/> COPD                | <input type="checkbox"/> Coronary Heart Disease     | <input type="checkbox"/> Peripheral Vascular Disease |                                                   |
| <input type="checkbox"/> Crohns Disease      | <input type="checkbox"/> Congestive Heart Failure   | <input type="checkbox"/> Prostate Cancer             |                                                   |
| <input type="checkbox"/> CVA /Stroke         | <input type="checkbox"/> Valvular Heart Disease     | <input type="checkbox"/> Renal Failure               |                                                   |
| <input type="checkbox"/> Dementia            | <input type="checkbox"/> Hepatitis A                | <input type="checkbox"/> Renal Insufficiency         |                                                   |

Please explain any items you checked and list any medical problems not included:

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**Past Surgical History** (check all that apply)

- |                                                      |                                                   |                                                   |                                                                                   |
|------------------------------------------------------|---------------------------------------------------|---------------------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> No surgeries                | <input type="checkbox"/> CABG                     | <input type="checkbox"/> Knee Arthroscopy/scope   | <input type="checkbox"/> Transplant Lung                                          |
| <input type="checkbox"/> Abdominal Surgery-type      | <input type="checkbox"/> Carotid Endarterectomy   | <input type="checkbox"/> Knee Replacement         | <input type="checkbox"/> Transplant Kidney                                        |
| <input type="checkbox"/> Aneurysm Repair             | <input type="checkbox"/> Cataract Extraction      | <input type="checkbox"/> Lumbar Discectomy        | <input type="checkbox"/> Sinus Surgery                                            |
| <input type="checkbox"/> Appendectomy                | <input type="checkbox"/> C-Section                | <input type="checkbox"/> Mastectomy               | <input type="checkbox"/> Uterus/Ovary Surgery                                     |
| <input type="checkbox"/> Left Aortic-Femoral Bypass  | <input type="checkbox"/> Cervical Discectomy      | <input type="checkbox"/> Mitral Valve Replacement | <input type="checkbox"/> Vasectomy                                                |
| <input type="checkbox"/> Right Aortic-Femoral Bypass | <input type="checkbox"/> Cholecystectomy          | <input type="checkbox"/> Nephrectomy              | <input type="checkbox"/> Surgery Complications                                    |
| <input type="checkbox"/> Bilateral A-F Bypass        | <input type="checkbox"/> Colon Resection          | <input type="checkbox"/> Stent Placement          | <input type="checkbox"/> Yes <input type="checkbox"/> No                          |
| <input type="checkbox"/> Aortic Valve                | <input type="checkbox"/> Craniotomy               | <input type="checkbox"/> Lung Resection           | <input type="checkbox"/> Anesthesia Complications                                 |
| <input type="checkbox"/> Breast Augmentation         | <input type="checkbox"/> Gastric Lap Band         | <input type="checkbox"/> Prostatectomy            | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Breast Lumpectomy           | <input type="checkbox"/> Cryosurgery/Cryotherapy  | <input type="checkbox"/> Rotator Cuff Re          | <input type="checkbox"/> Other                                                    |
| <input type="checkbox"/> Breast Reduction            | <input type="checkbox"/> Hernia Repair - Inguinal | <input type="checkbox"/> Tonsillectomy            |                                                                                   |
| <input type="checkbox"/> Bronchoscopy                | <input type="checkbox"/> Hernia Repair- Umbilical | <input type="checkbox"/> Tubal Ligation           |                                                                                   |
| <input type="checkbox"/> Cardiac/ Heart Cath         | <input type="checkbox"/> Hip Replacement          | <input type="checkbox"/> Transplant Heart         |                                                                                   |
| <input type="checkbox"/> Carpal Tunnel               | <input type="checkbox"/> Hysterectomy w/BSO       | <input type="checkbox"/> Transplant Liver         |                                                                                   |

Please list any surgeries not included:

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**Family History:**

Has any blood relative (father, mother, siblings, grandparents, aunts or uncle or other) had any of the following? If so, please list who next to problem.

- |                                                |                                                    |
|------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Alcoholism _____      | <input type="checkbox"/> Depression _____          |
| <input type="checkbox"/> Allergies _____       | <input type="checkbox"/> Diabetes _____            |
| <input type="checkbox"/> Anxiety _____         | <input type="checkbox"/> Cholesterol _____         |
| <input type="checkbox"/> Asthma _____          | <input type="checkbox"/> Heart Disease _____       |
| <input type="checkbox"/> Autoimmune _____      | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Blood Clots _____     | <input type="checkbox"/> Liver Disease _____       |
| <input type="checkbox"/> Breast Cancer _____   | <input type="checkbox"/> Lung Cancer _____         |
| <input type="checkbox"/> Cervical Cancer _____ | <input type="checkbox"/> Melanoma _____            |
| <input type="checkbox"/> Colon Cancer _____    | <input type="checkbox"/> Osteoporosis _____        |
| <input type="checkbox"/> Colon Polyp _____     | <input type="checkbox"/> Seizures _____            |
| <input type="checkbox"/> Migraine _____        | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Prostate Cancer _____ | <input type="checkbox"/> NEGATIVE FAMILY HISTORY   |
| <input type="checkbox"/> Stroke _____          |                                                    |

**Social history**

Marital Status (circle one):    Single      Married      Divorced      How many children do you have? \_\_\_\_\_  
Who do you live with? \_\_\_\_\_  
What is your occupation? \_\_\_\_\_  
How many years of education do you have? \_\_\_\_\_  
Do you have home health? If so, please list name of company. \_\_\_\_\_

**Risk Factors**

Tobacco Use: Yes\_\_\_ No\_\_\_      Current: Yes\_\_\_ No\_\_\_      Year started \_\_\_\_\_      Packs/Day \_\_\_\_\_      Cigars/week \_\_\_\_\_  
Year Quit: \_\_\_\_\_      Smokless cans/day \_\_\_\_\_  
Alcohol Use: Yes\_\_\_ No\_\_\_      Drinks/day \_\_\_\_\_      Type \_\_\_\_\_  
Drug Use: Yes\_\_\_ No\_\_\_      Type/Frequency \_\_\_\_\_  
Caffeine Use (circle one) Rare    Sometimes    Heavy  
Exercise (Circle one) Never    Some days    Most days    Daily  
Seatbelt Use (circle one) Never    Sometimes    Always  
Sun Exposure (circle one) Remote    Rarely    Occasionally    Frequently  
Heart Attack in Father before age 55      Yes\_\_\_ No\_\_\_  
Heart Attack in Mother before age 65      Yes\_\_\_ No\_\_\_



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**Review of Systems** (circle all that apply)

Please indicate whether you have recently (last month) had problems with any of the following.

<b>General:</b>	Decreased appetite    Dizziness    Fatigue    Fever    Weakness    Unintentional weight loss Weight gain
<b>Eyes:</b>	Eye discharge    Halos    Eye irritation    Recent visual changes
<b>Ears, Nose and Throat:</b>	Allergy/sinus problems    Difficulty swallowing    Disruptive snoring    Earache    Hearing loss Nasal congestion    Postnasal drip    Runny nose    Sneezing    Voice change
<b>Cardiovascular:</b>	Chest pain    Leg cramps with exertion    Palpitations/irregular heartbeats Swelling of the hands or feet    Passing out
<b>Respiratory:</b>	Chest congestion    Cough    Coughing up blood    Shortness of breath Sleep disturbance due to breathing    Wheezing
<b>Gastrointestinal:</b>	Abdominal bloating    Abdominal pain    Change in bowel habits    Difficulty swallowing Constipation    Diarrhea    Acid reflux/indigestion    Black, tarry stool    Nausea Rectal bleeding    Vomiting
<b>Genitourinary: Female:</b>	Decreased libido    Breast pain    Pain with urination    Pain with intercourse Blood in the urine    Urinary incontinence    Nipple discharge    Pelvic pain Urinary frequency    Urinary urgency    Vaginal discharge    Vaginal dryness
<b>Genitourinary: Male:</b>	Decreased libido    Decreased urinary flow    Discharge    Pain with urination Erectile dysfunction    Blood in the urine    Urinary incontinence    Urinating at night Urinary frequency    Urinary hesitancy
<b>Musculoskeletal:</b>	Back pain    Joint pain    Joint swelling    Muscle aches    Muscle cramps
<b>Dermatologic:</b>	Acne    Hair loss    Nail problems    Itching    Rash    Changing moles
<b>Neurological:</b>	Difficulty walking    Double vision    Frequent falling    Headaches    Muscle weakness Numbness    Seizures    Sudden loss of vision    Tremors
<b>Psychiatric:</b>	Anxiety    Depression    Insomnia
<b>Endocrine:</b>	Excessive thirst    Excessive urination    Intolerance to cold    Intolerance to heat
<b>Hematological:</b>	Easy bruising    Abnormal bleeding    Enlarged lymph nodes
<b>Allergy:</b>	Itchy eyes    Hives    Seasonal allergies