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)?

Preferred Pharmacy

_____

Allergies (foods and drugs)

Please indicate type of reaction next to each.

_____
_____
_____

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)

___ Abnormal Pap Smear
___Anemia
___ Anxiety
___ Asthma
___ Atrial Fibrillation
___ Bipolar Disorder
___ Blood Transfusion
___ Breast Ca.
___ Cervical Ca.
__ Chronic Back Pain
__ Colon Cancer
__ COPD
__ Crohns Disease
__ CVA /Stroke
__ Dementia
___ Depression
___ Diabetes, Gestational
___ Diabetes Type 1
___ Diabetes Type 2
___ Diverticulosis
___ DVT
___ Dyslipidemia
___ Fibrocystic Breast Disease
___ GERD
___ Gout
___ GI Bleed (upper/lower)
___ Coronary Heart Disease
___ Congestive Heart Failure
___Valvular Heart Disease
___ Hepatitis A
__ Hepatitis B
___ Hepatitis C
___ Hypertension
___ Hyperthyroidism
___ Hypothyroidism
___ Kidney Stone
___ Liver Disease
___ Heart Attack
___ Osteoarthritis
___ Osteoporosis
___ Peptic Ulcer Disease
___ Peripheral Vascular Disease
___ Prostate Cancer
___ Renal Failure
___ Renal Insufficiency
___ Rheumatoid Arthritis
___ Seizure Disorder
___ Skin Cancer
___ Substance Abuse
___ Thyroid Disorder
___ Tuberculosis
___ UTI – recurrent
___ Varicose Veins/Phlebitis
___NO MEDICAL PROBLEMS

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

_____
_____
_____
_____

Past Surgical History (check all that apply)

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

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.

___ Alcoholism _____
___ Allergies _____
___ Anxiety _____
___ Asthma _____
___ Autoimmune _____
___ Blood Clots_____
___ Breast Cancer _____
___ Cervical Cancer _____
___ Colon Cancer_____
___ Colon Polyp_____
___Migraine_____
___Prostate Cancer_____
___ Stroke_____
___ Depression _____
___ Diabetes _____
___ Cholesterol _____
___ Heart Disease_____
___ High Blood Pressure_____
___ Liver Disease_____
___ Lung Cancer _____
___ Melanoma _____
___ Osteoperosis_____
___ Seizures _____
___ Other _____
___ NEGATIVE FAMILY HISTORY

Social history

Marital Status (circle one): Single Married Divorced How many children do you have? _____
Who do you live with? _____
What is your occupaion? _____
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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Preventative Care:
We strongly believe that prevention is the key to keeping you happy and healthy. We closely follow national recommendations in screening for cancer, heart disease, cholesterol problems, diabetes, high blood pressure, osteoporosis, and many vaccine preventable diseases.

In order to help us with our goal please also fill out the following.

When was your last physical exam or well woman exam? _____

Cholesterol
Have you had your cholesterol levels tested in the last 5 years?
□ Yes □ No
_____
□ Normal □ High

If high, what was the number _____

Colon Cancer Screening (for patients over 50)
Have you ever had colon cancer screening? □ Yes □No
Colonoscopy? If so when _____
Where_____
Sigmoidoscopy? If so when_____
Where_____
Barium Enema? If so when_____
Where_____
Hemoccult/ blood in stool? If so when_____
Where_____

Immunizations
When was your last tetanus vaccine _____
When was your last flu vaccine _____
When was your last pneumonia vaccine _____

Osteoporosis (bone thinning and weakening)
When was your last bone mineral density _____
Where_____
Do you know the results _____

Males only
Testicular Cancer
When was your last testicular exam_____

Prostate Cancer Screening
When was your last exam_____
PSA?_____

Females only
Cervical Cancer
When was your last pap smear _____
Where _____
□ Normal □ Abnormal
Have you had a hysterectomy □ Yes □ No
Have you ever been diagnosed with cervical, uterine or ovarian cancer
□ Yes □ No
What type _____

Mammogram
When was your last breast exam_____
When was your last mammogram _____
Where _____
□ Normal □ Abnormal

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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.

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

Sign up for text messages!

Receive appointment reminders on your cell phone.

It's easy to get these helpful texts!

1. **Give us your cell phone #**
2. **Text** HTPN **to 622622**

Message and data rates may apply. Text HELP to 622622 to receive help, STOP to 622622 to opt-out. Visit txt.tvox.com for more info.