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)?

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
___ Cryn Surgery
___ 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