Health History Form

Established Patient

Annual / Wellness Exam

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.

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

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Have you seen or referred yourself to another physician since your last visit? What was the reason?

____

Medications

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

Are you taking the above medications as prescribed (Y/N)? ______

If not, please explain.

____

____

____

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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.

____

Past Medical History/Problems

Please provide any updates to your medical history since your last visit.

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____

Past Surgical History

Please list any surgeries you may have had since your last visit.

____
____

Family History:

Has any blood relative (father, mother, siblings, grandparents, aunts or uncle or other) been diagnosed with the following since your last visit? 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

Please provide any update to the following since your last visit.
Marital Status (circle one): Single Married Divorced Number of children ____________
Who you live with ______________________________
Occupation ______________________________
Years of education______________________________
Home health. If so, please list name of company.______________________________

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Risk Factors

Please provide any update to the following since your last visit.

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___

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 provide any update to the following since your last visit.

A physical exam or well woman exam ____

Cholesterol

Cholesterol level testing

☐ Yes ☐ No

____

☐ Normal ☐ High

If high, what was the number _________

Colon Cancer Screening (for patients over 50)

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

Tetanus vaccine ________________

Flu vaccine ____________________

Pneumonia vaccine ______________

Osteoporosis (bone thinning and weakening)

Bone mineral density ____________

Where______________________________

Do you know the results_________________________

Males only

Testicular Cancer

Testicular exam________________

Prostate Cancer Screening

When was your last exam______________________

PSA?______________________________

Females only

Cervical Cancer

Pap smear ________________

Where ______________________________

☐ Normal ☐ Abnormal

Hysterectomy ☐ Yes ☐ No

Diagnosed with cervical, uterine or ovarian cancer?

☐ Yes ☐ No

Type______________________________

Mammogram

Breast exam ________________

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