Health History Form
New Patient

Name: _____

DOB: _____

Date: _____

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 today's visit. Please include the date of onset and any symptoms associated with the problems.

_____

_____

If female, please provide:

LMP Date: _____ Birth Control: _Yes _No

Type: _____

Allergies: (food or drugs)

Please indicate type of reaction next to each.

_____

_____

Medications: (if more space is needed please use back of paper)

Medication Name	Dose & Frequency	Need Refill (Y/N)

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 Ca.
__Congestive Heart Failure
__COPD
__Coronary Heart Disease
__Crohn's 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)
__Hepatitis A
__Hepatitis B
__Hepatitis C
__Heart Attack
__Hypertension
__Hyperthyroidism
__Hypothyroidism
__Kidney Stone
__Liver Disease
__Osteoarthritis
__Osteoporosis
__Peptic Vascular Disease
__Prostate Ca.
__Renal Failure
__Renal Insufficiency
__Rheumatoid Arthritis
__Seizure Disorder
__Skin Disorder
__Substance Abuse
__Thyroid Disorder
__Tuberculosis
__UTI-recurrent
__Valvular Heart Disease
__ 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
__Aortic Valve
__Breast Augmentation
__Breast Lumpectomy
__Breast Reduction
__Bronchoscopy
__Cardiac/Heart Cath
__Carpal Tunnel
__CABG
__Carotid Endarterectomy
__Cataract Extraction
__C-Section
__Colon Resection
__Craniotomy
__Cryn Surgery
__Gastric Lap Band
__Hernia Repair-Inguinal
__Hernia Repair-Umbilical
__Hip Replacement
__Hysterectomy w/BSO
__Knee Arthroscopy
__Knee Replacement
__Left Aortic-Femoral Repair
__ Lumbar Discectomy
__ Lung Resection
__ Mastectomy
__Prostatectomy
__Right Aortic-Femoral Repair
__Rotator Cuff Repair
__Sinus Surgery
__ Stent Replacement
__Tonsillectomy
__Transplant Heart
__Transplant Kidney
__Transplant Liver
__Transplant Lung
__Tubal Ligation
__Uterus/Ovary Surgery
__Vasectomy
__Surgery Complications

__Cervical Discectomy __ Mitral Valve Replacement __Anesthesia Complications
__Cholecystectomy __ Nephrectomy __Other

Please list any surgeries not included:

_____

_____

_____

Family History:

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

__Alcoholism
__Allergies
__Anxiety
__Asthma
__Autoimmune
__Blood Clots
__Breast Cancer
__Cervical Cancer
__Cholesterol
__Colon Cancer
__Colon Polyp
__Depression
__Diabetes
__Heart Disease (before 55 for males, before 65 for females)
__High Blood Pressure
__Liver Disease
__Lung Disease
__Melanoma
__Migraine
__Osteoporosis
__Prostate Cancer
__Seizures
__Stroke
__Other
__NEGATIVE MEDICAL HISTORY

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. _____

Social History: (continued)

Alcohol Use: _Yes _No Drinks/per 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 (circle one)	Never	Sometimes	Always	
Sun Exposure (circle one)	Remote	Rarely	Occasionally	Frequently

Prevention Care Screening:	Month & Year	Results
Tobacco Use:	_____	_____
Cholesterol:	_____	_____
HDL:	_____	_____
LDL:	_____	_____
Mammogram:	_____	_____
Pap Smear:	_____	_____
Chlamydia Screen:	_____	_____
Colonoscopy:	_____	_____
Fecal Occult Blood:	_____	_____
Bone Density:	_____	_____
Tetanus Booster:	_____	_____
Flu Vaccine:	_____	_____
Pneumonia/Pneumovax:	_____	_____
Prevnar-13:	_____	_____
Prenvar-23:	_____	_____
Shingles Vaccine:	_____	_____
Dilated Retinal Exam:	_____	_____
Hemoglobin A1C:	_____	_____
Prostate Exam:	_____	_____
Physical Exam/Wellness Visit:	_____	_____
Physician Breast Exam:	_____	_____
Dental Check-Up:	_____	_____

Mood:

Over the last two weeks, have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things? _Yes _No
2. Feeling down, depressed, or hopeless? _Yes _No

Do you have a living will?	_Yes _No
Do you have a medical power of attorney?	_Yes _No
Do you have a personal will?	_Yes _No
Do you have or desire a DO NOT RESUSCITATE ORDER (DNR)?	_Yes _No

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 Weakness, Unintentional weight loss, Weight Gain
Eyes:	Eye discharge, Halos, Eye Irritation, Recent visual change
Ears, Nose, and Throat:	Allergy/Sinus, 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 of 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 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 urine, Urinary incontinence, Urinating at night, Urinary frequency, Urinary hesitation
Musculoskeletal:	Back pain, Joint pain, Joint swelling, Muscle aches, Muscle cramps
Dermatologic:	Acne, Hair loss, Nail problems, Itching, Rash, Changing moods
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