Patient Health History

Date:_____ Acct#_____

Last Name:_____ First Name:_____ MI:_____

Height:_____ Weight:_____

Please list the reason(s) for your visit to our office today:_____

_____

Please list all allergies including medications, shellfish, iodine, tape, latex, etc.)

Medication Reaction

1. _____

2._____

3 _____

Please list all medications that you are currently taking. This includes any over-the counter medications. (Please include any vitamins, herbs and /or appetite suppressants.) If additional space is needed we will provide an additional page for your convenience.

Medication and Dosage	#Times per day	Medication and Dosage	#Times per day
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Do you have any physical limitations? Yes *I* No Explain_____

_____

Have you ever had a blood transfusion? Yes *I* No When?_____ Reaction? Yes *I* No

Please circle any of following surgeries you have had and indicate date of surgery:

Tonsils Eye Cataract Ear Nose

Carotid (neck artery) Luo Back

Heart: Bypass *I* Valve Colon Gallbladder

Liver Spleen Appendix Arteries in leg(s)_____

Aneurysm Skin Cancers Bums

Hernia_____ Other:_____

Have you ever been hospitalized for any reason besides surgery: Yes *I* No

Reason_____

_____

_____

Please circle any of the following medical problems you now have or have had in the past:

Measles	Mumps	Whooping cough	Chicken pox
Smallpox	Polio	Rheumatic Fever	Diphtheria
Rubella	Blood clot in artery	Blood clot in vein	Head injury
Emphysema	Stroke	Asthma	Wheezing
Hepatitis	Pneumonia	Blood clot in lung	Blindness
Tuberculosis	Cataracts	Kidney Failure	Heart Valve Disease
Heart Attack	Glaucoma	Kidney Stones	Diabetes
High Blood Pressure	Gallstones	Thyroid Problems	Cancer: Type_____
Coronary Artery Disease	Leg Cramps	Sleep Apnea	Other:_____

Angina Shortness of Breath: _____ at rest _____ with exertion _____

Do you wear glasses? Yes / No Reason: Reading / Near-sightedness / Far-sightedness / other

Do any of your blood relatives (mother, father, sister, brother, child, grandparent) have any of the following conditions? (Circle all that apply)

High Blood Pressure	Glaucoma	Kidney Failure	Heart Valve Disease
Heart Disease / Attack	Stroke	Tuberculosis	Diabetes
Epilepsy	Gout	Asthma	Thyroid Disease
Arthritis	Blood Disorders	Mental Disorders	

Cancer: Type._____

Usual Diet_____

Do you drink alcohol? Yes / No Beer / Wine / Hard Liquor # of 8-oz glasses per day_____

Do you now or have your ever smoked? Yes / No #of packs per day_____ # of years_____

When did you quit? Cigars? Yes / No Pipe? Yes / No

Do you use illicit drugs or abuse prescription medicines? Yes / No Type_____ How often?_____

Do you exercise? Yes / No #times per week_____ #minutes each time_____

Number of children ____ Health status: Well / Chronic illness Number Decease4_____

Parents: Mother: Living / Deceased – Age:_____ Father: Living / Deceased – Age:_____

Cause of death (if known):_____

Number of brothers and sisters:_____ Health Status: Well / Chronic illness / Deceased (#_____,

REVIEW OF SYSTEMS

The following questions relate to health problems you have or have had in the past. Please circle the appropriate conditions.

Neurological: seizures, vertigo, previous stroke, aneurysm, heating impairment, other

Endocrine/Hormonal: thyroid disease, adrenal disease, goiter, other

Ophthalmologic: glaucoma, cataracts, visual impairment, other

Ear, Nose, Throat: snoring, hearing aids, sinus, hoarseness, nose bleeds

Gastrointestinal: hiatal hernia, reflux esophagus, esophageal disease, ulcers, gastritis, duodenitis, hepatitis, yellow jaundice, other liver disease, gallstones, gallbladder disease, pancreatic disease, chronic constipation, diarrhea, diverticulitis, GI bleed, Crohn's, ulcerative colitis, irritable bowel, other intestinal disease

Renal: renal insufficiency, dialysis, kidney stones, other

Urological: prostate disease, frequent bladder infections, impotence, other

Immunological: gout, rheumatoid arthritis, lupus, other

Infectious: AIDS, hepatitis, TB, syphilis, endocarditis, other

Hematologic: anemia, bleeding problem, clotting problem, leukemia, other

Psychological: depression, anxiety, panic attacks, anorexia, bulimia, other

Physical disability: problems with walking, other

Dermatologic: psoriasis, eczema, petichiae, other

Vascular: varicose veins, aortic aneurysm

Malignancy: cancer, tumor, lymphoma

Musculoskeletal: joint pain, arthritis, weakness

Miscellaneous: osteoporosis, congenital syndrome, Marfan's, Turner's

I have reviewed the above information with the patient. _____ (RN/PA)

Patient Health History has been reviewed by _____ on _____
(Physician's Signature and Date)