

# PATIENT HEALTH/HISTORY FORM

Chart # \_\_\_\_\_

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

Drug Allergies \_\_\_\_\_

Medicine Intolerance \_\_\_\_\_

Medications	Name	Strength	How Often
List All Medications That You Are Now Taking, Include Over The Counter Rx.			

Medications	Name	Strength	How Often
List All Medications That You Are Now Taking, Include Over The Counter Rx.			

**Past Hospitalization/Surgeries:**

(Indicate year admitted to hospital & reason)

Year	Illness or Surgery

**Major Medical Problems:**

Code	Medical Problem

**Family History:**

	Alive & Well	Deceased	Follow The Lines Across The Page And Mark The Appropriate Box <b>Cause of Death (Age)</b>	High Blood Pressure	Heart Disease	Epilepsy	Diabetes	Cancer	Asthma	Hayfever	Arthritis	Kidney Disease	Glaucoma	Stroke	Migraine	Mental Illness	Alcoholism	Bleeds Easily	Anemia	Psoriasis	Eczema	
<b>Paternal</b>	Father																					
	Grand Parents																					
<b>Maternal</b>	Mother																					
	Grand Parents																					
	Uncles, Aunts																					
	Brothers, Sisters																					

**Social History:** Marital Status \_\_\_\_\_

Tobacco Use \_\_\_\_\_ Type & Quantity \_\_\_\_\_ Caffeine Use \_\_\_\_\_ Type & Quantity \_\_\_\_\_

Have you, or anyone in the home, been subjected to neglect, physical, sexual, emotional or other abuse? If yes, what type, when, treatment etc. \_\_\_\_\_

Have you, or anyone in the home, been subjected to domestic violence? If yes, explain. \_\_\_\_\_

Have you, or anyone in the home, been treated for mental health problems or alcohol, prescription or street drug use? If yes, when, type and/or quantity. \_\_\_\_\_

**Immunizations:**

Pneumonia - Date: \_\_\_\_\_  
 Diphtheria/Tetanus Booster - Date: \_\_\_\_\_  
 Other \_\_\_\_\_ - Date: \_\_\_\_\_  
 Other \_\_\_\_\_ - Date: \_\_\_\_\_

**Physician Reviewer:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**(OVER)**

**Women:**

Last Pelvic Exam \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Last Pap Smear \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Last Mammogram \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Any History of Abnormal Pap Smear? Date \_\_\_\_\_ Abnormality \_\_\_\_\_

Birth Control Method \_\_\_\_\_

Number of Pregnancies \_\_\_\_\_ Number of Children \_\_\_\_\_

Number of Abortions \_\_\_\_\_ Number of Miscarriages \_\_\_\_\_

**Review of Systems:** (Mark C for Current problems. Check (#) box for past symptoms/diseases)

<input type="checkbox"/> Headache	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Trouble Starting Urine	<input type="checkbox"/> Skin, Specify
<input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Asthma	<input type="checkbox"/> Trouble Holding Urine	<input type="checkbox"/> History of Blood Transfusion
<input type="checkbox"/> Chills	<input type="checkbox"/> COPD	<input type="checkbox"/> Trouble with Sexual Function	<input type="checkbox"/> Homosexual Relations
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> History of Syphilis	<input type="checkbox"/> IV Drug Use
<input type="checkbox"/> Emotional Problems	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> History of Gonorrhea	<input type="checkbox"/> Other Problems Not Specified Above:
<input type="checkbox"/> Depression	<input type="checkbox"/> Cough	<input type="checkbox"/> History of Herpes	_____
<input type="checkbox"/> Blurring of Vision	<input type="checkbox"/> Lung Tumor	<input type="checkbox"/> History of Joint Pain	_____
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Other	<input type="checkbox"/> Back Pain	_____
<input type="checkbox"/> Other Eye Problems	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Chronic Bone Infection	_____
<input type="checkbox"/> Ear Ache	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Problems with Muscles	_____
<input type="checkbox"/> Ear Secretions	<input type="checkbox"/> Frequent Belching	<input type="checkbox"/> Repeated Cramps	_____
<input type="checkbox"/> Other Ear Problems	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Osteoarthritis	_____
<input type="checkbox"/> Nose Bleed	<input type="checkbox"/> Vomit Blood	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Gallbladder Problem	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> Trouble With Smell	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Pancreas Problems	<input type="checkbox"/> Weakness on One Side	_____
<input type="checkbox"/> Neck Mass	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Swollen Glands	_____
<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Bloody Stool	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Change in Bowel Habits	<input type="checkbox"/> Bleeding	_____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Bruising	_____
<input type="checkbox"/> Prior Heart Attack	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Immune Disease	_____
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> Blood Factor Deficiency	_____
<input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Hay Fever	_____
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Other	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Chronic Rash	_____

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_