PATIENT HEALTH HISTORY

Please take your time and answer these questions accurately. The information you provide will be entered into your medical record. Use an additional piece of paper if needed and bring with you to appointment.

Patient Name	**Date:**
Medications: List all medications, <u>dosage</u>, and <u>how many times taken each day</u>.	
Allergies: (List all drug allergies)	
Immunizations:	
Were childhood immunizations completed?	☐ Yes ☐ No
When was your last tetanus shot?	Date:
When was your last flu shot?	Date
Have you received the pneumonia vaccine?	☐ Yes ☐ No If yes, Date:
Have you received the Zostavax (Shingles Vaccine)?	☐ Yes ☐ No If yes, Date:
List all DIAGNOSES that have been given to you (such as Diabetes, hypertension, cancer etc.)	
List all SURGERIES you have had and dates:	
PREVENTATIVE MEDICINE SECTION (Please complete the appropriate boxes):	
WOMEN: Date of last ***Mammogram***: _____ Exam was: ☐ Normal ☐ Abnormal Location of last mammogram: _____	Date of last ***Pap Smear/ Pelvic Exam***: _____ Exam was: ☐ Normal ☐ Abnormal Gynecologist Name: _____
MEN: Over age 40 - Have you been screened for ***Prostate Cancer***? ☐ Yes ☐ No Date: _____ Were the results of the test ☐ Normal ☐ Abnormal	
WOMEN/MEN: Date of last ***Colonoscopy***: _____ Results: ☐ Normal ☐ Abnormal	
WOMEN/MEN: Date of last ***Cholesterol Test***: _____ Results: ☐ Normal ☐ Abnormal	
WOMEN/MEN: Date of last ***Bone Density***: _____ Results: ☐ Normal ☐ Abnormal	

FAMILY HISTORY: ***List chronic medical problems especially cancer/heart disease/diabetes:***

Mother: ☐ Living ☐ Deceased If deceased, list age of death: _____ List any chronic medical problems affecting your mother: _____

Father: ☐ Living ☐ Deceased If deceased, list age of death: _____ List any chronic medical problems affecting your father: _____

Siblings/Other Family members: List any chronic medical problems:_____

_____

SOCIAL HISTORY: **Employer:** _____ **Occupation**: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Do you have a history of **TOBACCO USAGE**: ☐ Yes ☐ No Do you currently smoke? ☐ Yes ☐ No

If you are a **CURRENT** smoker, how many years have you smoked? _____

If you have **QUIT** smoking how many years ***DID*** you smoke prior to quitting? _____

On average, now or before you quit smoking, how many packs per day did you smoke? _____

Do you **EXERCISE** regularly? ☐ Yes ☐ No If so, what type? _____

Do you drink **ALCOHOL**? ☐ Yes ☐ No If so, what type? _____

How often do you consume alcohol? _____ How many drinks do you normally have? _____

Do you use **ILLEGAL DRUGS**? ☐ Yes ☐ No If so, what type and how often? _____

REVIEW OF SYSTEMS: (PRINT THIS FORM AND CIRCLE ALL THAT ARE CURRENTLY CAUSING YOU PROBLEMS)	
GENERAL	Fever ☐ Chills ☐ Fatigue ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss ☐
HEENT	Vision Changes ☐ Headaches ☐ Hearing Loss ☐ Sore Throat ☐
RESPIRATORY	Cough ☐ Wheezes ☐ Shortness of Breath ☐
CARDIOVASCULAR	Chest Pain ☐ Rapid/Irregular Heartbeat ☐ Swelling ☐ Fainting ☐
VASCULAR	Pain in legs with walking that is relieved with rest (claudication) ☐
GI	Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood Stool ☐ Black Tarry Stool ☐ Abdominal Pain ☐ Reflux ☐
GU	Pain when Urinating ☐ Blood in Urine ☐
REPRODUCTIVE (Men Only)	Sexual or Erectile Dysfunction ☐
REPRODUCTIVE (Women Only)	Vaginal discharge ☐ Painful Menstruation ☐ Excessive Bleeding ☐
ENDOCRINE	Frequent Urination ☐ Excess Thirst ☐ Excess Appetite ☐ Heat Intolerance ☐ Cold Intolerance ☐
NEUROLOGICAL	Dizziness ☐ Emotional Disturbances ☐ Weakness ☐ Numbness ☐ Tremor ☐
DERMATOLOGY	Itching ☐ Rash ☐
MUSCULOSKELETAL	Joint Pain ☐ Back Pain ☐ Swelling of Joints ☐ Weakness ☐ Change in Gait ☐ Muscle Pain ☐
HEME	Excessive Bruising ☐ Excessive Bleeding ☐
IMMUNE	Food Allergies ☐ Environmental Allergies ☐