

SSN: _____

Date of Birth: _____

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Social Security Number (SSN) _____ Date of Birth _____ Appointment Date _____

Patient's Last Name _____ First _____ MI ___ Preferred Name _____

Male Female Race _____ Pharmacy Preference (include location) _____

Name of Primary Care (Family) Physician _____ Name of referring physician _____

***List any and all Doctors you are seeing and why:**

Dr.'s Full Name	Why you see this Doctor

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)

No Yes If yes, please list below *include dosages.*

(TAB1) PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED (PLEASE PRINT NEATLY)

Medication Name	Dosage	How often?	Prescribing Doctor

(TAB 2) Are you allergic to ANY medications? No Yes If yes, please list below.

Name of Medication	Type of Reaction

(TAB 3) NON MEDICATION ALLERGIES

Are you allergic to seafood? No Yes If yes, what reaction do you have? _____

Are you allergic to things that touch your skin, such as latex, tape, metal? No Yes latex tape metal

If yes, what reaction do you have? _____

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(TAB 4) Have you ever been *DIAGNOSED* with any major health problems? Including but not limited to:

CHILDHOOD DISEASES:

- Measles Yes What year? _____
- German Measles Yes What year? _____
- Mumps Yes What year? _____
- Scarlet Fever Yes What year? _____

- Diverticulitis Yes What year? _____
- Reflux Yes What year? _____
- Hepatitis Yes What year? _____
- Hernia Yes What year? _____
- Pancreatitis Yes What year? _____
- Stomach ulcer Yes What year? _____

CANCER:

Type _____ Yes What year? _____

EYES:

- Cataracts Yes What year? _____
- Glaucoma Yes What year? _____
- Retinal Detachment Yes What year? _____

EARS:

- Hearing loss from aging Yes What year? _____
- Hearing loss from trauma Yes What year? _____
- Hearing loss unknown cause Yes What year? _____

HEART & BLOOD VESSELS:

- Angina Yes What year? _____
- Cerebral Vascular Accident Yes What year? _____
- Heart Attack Yes What year? _____
- Heart Disease Yes What year? _____
- High Blood pressure Yes What year? _____
- Pericarditis Yes What year? _____
- Blood Clots in Arms or Legs Yes What year? _____

LUNGS & RESPIRATORY:

- Tuberculosis Yes What year? _____
- Asthma Yes What year? _____
- Chronic bronchitis Yes What year? _____

STOMACH & DIGESTIVE:

Cirrhosis or enlarged liver Yes What year? _____

KIDNEY & GENDER PROBLEMS:

- Renal failure Yes What year? _____
- Prostate Enlargement Yes What year? _____
- Are you pregnant? Yes

SKIN & BREAST:

- Psoriasis Yes What year? _____
- Shingles Yes What year? _____

BRAIN & NERVOUS SYSTEM:

- Epilepsy Yes What year? _____
- Stroke Yes What year? _____

GLANDS, HORMONES, & SUGAR CONTROL PROBLEMS:

- Diabetes (Type _____) Yes What year? _____
- Goiter Yes What year? _____
- Thyroid deficiency Yes What year? _____
- Thyroid excess Yes What year? _____

BLOOD & LYMPH NODE PROBLEMS:

- Anemia Yes What year? _____

ALLERGIES, IMMUNE & INFECTIOUS PROBLEMS:

- HIV Yes What year? _____
- Infectious mononucleosis Yes What year? _____

OTHER (Please Specify): _____

(TAB 5) SURGERIES AND HOSPITALIZATIONS

Have you been hospitalized (not for surgery)? No Yes

If **yes**, list hospitalizations, the reason for admission and the date. _____

Have you had surgery? No Yes

If **yes**, list any surgeries and when they were done. _____

Have you had problems with anesthesia (being numbed or put to sleep)? No Yes

If **yes**, please list what sort of problems. _____

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(TAB 6) SERIOUS INJURIES

Have you ever had a serious injury such as head, neck, back or other injury? No Yes

If yes, list and describe the type of injury and when it occurred. _____

(TAB 8) FAMILY HISTORY

Specific Anesthesia Problem Mother Father Brother Sister

Heart and Blood Vessels:

Heart Disease Mother Father Brother Sister

High Blood Pressure Mother Father Brother Sister

Lungs and Respiratory:

Lung Cancer Mother Father Brother Sister

Asthma Mother Father Brother Sister

Bones, Joints & Muscles:

Arthritis Mother Father Brother Sister

Osteoporosis Mother Father Brother Sister

Brain and Nervous:

Dementia Mother Father Brother Sister

Neurotubule disease Mother Father Brother Sister

Stroke Mother Father Brother Sister

Blood & Lymph Node problems:

Bleeding/clotting problem Mother Father Brother Sister

Other _____ Mother Father Brother Sister

(TAB 9) SOCIAL HISTORY

Place of employment: _____

Occupation: _____ Check here if you are retired. Marital Status _____

Have you ever used tobacco in any form? No Yes

If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Are you exposed to second hand smoke? No Yes

Have you ever used alcohol in any form? No Yes

If yes, please complete the following:

Type of Alcohol	From year	To year
Beers per week: _____		
Wine glasses per week: _____		
Other: (list type) _____		

Hand dominance: Right Left

Living setting: Alone Spouse Children Mother Father Nursing Home Assisted living other _____

(TAB 10) REVIEW OF SYSTEMS: List any problems you have or have recently had in the follow areas:

General Health (Fatigue, Fever, Unintentional weight loss, Unintentional weight gain, or other problems) No Yes

If yes, please list problems. _____

Eye and Ear (Loss of vision, Hearing loss, Ringing in ears, or other problems) No Yes

If yes, please list problems. _____

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Heart and Blood Vessels (Chest pain, Irregular heart beat, Shortness of breath, or other problems) No Yes
If yes, please list problems. _____

Lungs and Respiratory system (Shortness of breath, Frequent cough, Wheezing, or other problems) No Yes
If yes, please list problems. _____

Stomach and Digestive system (Abdominal pain, Diarrhea, Heartburn, Nausea, Vomiting, or other problems) No Yes
If yes, please list problems. _____

Kidney or bladder or sexual health
Male: (Loss of sexual interest, Change in urinating pattern or other problems) No Yes
If yes, please list problems. _____

Female: (Unusual menstrual bleeding, Stress incontinence or other problems) No Yes
If yes, please list problems. _____

Bones, Joints and Muscles (Painful joints, Loss of muscle strength, Swelling of joints) No Yes
If yes, please list problems. _____

Skin and Breast (Discharge from nipples, Rash, or other problems) No Yes
If yes, please list problems. _____

Brain or Nervous system (Difficulty remembering, Loss of consciousness, Seizures, or other problems) No Yes
If yes, please list problems. _____

Mental and Emotional health (Nervousness, Depression, or other problems) No Yes
If yes, please list problems. _____

Blood or Lymph nodes (Excessive bleeding, Easy bruising, or other problems) No Yes
If yes, please list problems. _____

Allergies, infections, and immune system (Abnormal infections, Hives, or other problems) No Yes
If yes, please list problems. _____

This information is very important for us to have for your treatment. Thank you very much for filling out these forms completely.