# PATIENT HEALTH HISTORY

## REASON FOR YOUR VISIT

*What medical issues bring you to our clinic today?*

## PRIMARY CARE PHYSICIAN (PCP)

*Do you currently have a PCP?* ☐ *Yes* ☐ *No*

*When did you last see this Physician?* _____

*Please provide the physician's name, address & phone:*

## REFERRING PHYSICIAN

*Were you referred to our clinic by another physician?*

☐ *Yes* ☐ *No*

*Please provide name, address & phone:*

## OTHER TREATING PHYSICIANS ☐ *Yes* ☐ *No*

*Please provide the physician names, addresses & phone #'s:*

## RECENT STUDIES

| | | |
|---|---|---|
| *Do you have any chest x-ray, x-rays, lab work* | ☐ *Yes* | ☐ *No* |
| *Endoscopy, colonoscopy, or other test results?* | ☐ *Yes* | ☐ *No* |
| *Heart studies?* | ☐ *Yes* | ☐ *No* |
| *Cardiac catheter?* | ☐ *Yes* | ☐ *No* |
| *Echo?* | ☐ *Yes* | ☐ *No* |
| *EKG?* | ☐ *Yes* | ☐ *No* |

*Other Tests/Studies:*_____

*If yes, who ordered the service and where was the study performed?*

## MEDICATIONS:

| | | |
|---|---|---|
| *Do you take antibiotics when you go to the dentist?* | ☐ *Yes* | ☐ *No* |
| *Have you ever taken steroid medications?* | ☐ *Yes* | ☐ *No* |
| *Have you used aspirin within the last 2 weeks?* | ☐ *Yes* | ☐ *No* |
| *Are you taking Plavix / Pradaxa?* | ☐ *Yes* | ☐ *No* |
| *Recent Chemo Therapy (within 30 days)* | ☐ *Yes* | ☐ *No* |
| *Have you ever had Bleomycin?* | ☐ *Yes* | ☐ *No* |
| *Have you ever had Doxorubicin / Adriamycin?* | ☐ *Yes* | ☐ *No* |

## PAST OPERATIONS:

| | | |
|---|---|---|
| *Any complications with prior surgery?* | ☐ *Yes* | ☐ *No* |
| *Have you ever had anesthesia problems?* | ☐ *Yes* | ☐ *No* |
| *Family history of anesthesia problems?* | ☐ *Yes* | ☐ *No* |

*List type of surgery & date:*

## ACTIVITY LEVEL (check most appropriate)

- ☐ *I am fully active*
- ☐ *I have symptoms but can carry out daily activities*
- ☐ *I am ambulatory more than 50% of the time and need occasional assistance*
- ☐ *I am ambulatory less than 50% of the time and require nursing care*
- ☐ *I am confined to a bed*

PLACE PATIENT LABEL HERE

## INJURY

☐ ***None***

☐ *Burn*
☐ *Fracture*
☐ *Gunshot wound*
☐ *Auto accident*
☐ *Head Injury or Concussion*
☐ *Noise exposure*
☐ *Stab wound*
☐ *Other trauma:* _____

*Was the injury the cause of your illness?* ☐ *Yes* ☐ *No*
Explain_____

Date of **Injury**, if applicable, or Date **Symptoms** began:

_____

**Place of Injury:** ☐ *Home / School* ☐ *Auto* ☐ *Work* ☐ *Other:*_____

## SOCIAL HISTORY

**Smoking:** ☐ *Yes* ☐ *No , quit after*_____*years.*
*If yes, # of years smoking:*_____ *# per day*_____
*Quit?*_____*months/years ago* ☐ *Yes*

**Alcohol:** ☐ *Yes* ☐ *No, quit after*_____*years*
*If yes, # drinks per week*_____

**IV Drugs?** ☐ *Yes* ☐ *No* **Marijuana:** ☐ *Yes* ☐ *No*
**Other Recreational Drugs?** ☐ *No* ☐ *Yes:* _____

*Check all that apply to you and your family members*

| | PERSONAL HISTORY | FAMILY HISTORY | |
|---|---|---|---|
| ***Illnesses:*** | ***You*** | ***Family*** | ***Which family member(s)*** |
| *Cancer (type)* | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | |
| *Stroke* | ☐ | ☐ | |
| *Lung Disease (Pneumonia)* | ☐ | ☐ | |
| *Severe Infections (eg. TB)* | ☐ | ☐ | |
| *MRSA* | ☐ | | |
| *Liver Disease* | ☐ | ☐ | |
| *Thyroid Disease* | ☐ | ☐ | |
| *Clots in the deep veins* | ☐ | ☐ | |
| *Organ Transplant* | ☐ | ☐ | |
| *Abnormal Chest X-ray* | ☐ | ☐ | |
| *Abnormal EKG* | ☐ | ☐ | |
| *Abnormal Bleeding* | ☐ | ☐ | |
| *Other:* | ☐ | ☐ | |

PLACE PATIENT LABEL HERE

**REVIEW OF SYSTEMS** *Please review and check "no" or "yes" box*

| | Any **current** problems with your health? | | Comments – Additional information |
|---|---|---|---|
| **General** | *Recent Weight gain / loss* | ☐ *Yes* ☐ *No* | Current Height: _____ Weight: _____ lbs |
| | *Fatigue / Trouble sleeping* | ☐ *Yes* ☐ *No* | |
| | *Fever / Chills / Night sweats* | ☐ *Yes* ☐ *No* | |
| **Ear / Nose / Mouth / Throat** | *Hearing Loss / Hearing Aid* | ☐ *Yes* ☐ *No* | |
| | *Ear Problems* | ☐ *Yes* ☐ *No* | |
| | *Nose Problems* | ☐ *Yes* ☐ *No* | |
| | *Mouth or Throat Problems* | ☐ *Yes* ☐ *No* | |
| | *Nose bleeds / Sinus Problems* | ☐ *Yes* ☐ *No* | |
| | *Dental Problems / Dentures* | ☐ *Yes* ☐ *No* | |
| | *Loose or Missing Tooth / Teeth* | ☐ *Yes* ☐ *No* | |
| **Eye** | *Wear glasses / contacts* | ☐ *Yes* ☐ *No* | |
| | *Eye problems* | ☐ *Yes* ☐ *No* | |
| | *Yellowing of white part of the eyes* | ☐ *Yes* ☐ *No* | |
| **Neurology** | *Problems with vision* | ☐ *Yes* ☐ *No* | |
| | *Headaches / Dizziness* | ☐ *Yes* ☐ *No* | |
| | *Seizures* | ☐ *Yes* ☐ *No* | |
| | *Fainting / Unconsciousness* | ☐ *Yes* ☐ *No* | |
| | *Numbness / Tingling / Weakness* | ☐ *Yes* ☐ *No* | |
| **Heart** | *Chest Pain* | ☐ *Yes* ☐ *No* | |
| | *Heart Murmur* | ☐ *Yes* ☐ *No* | |
| | *High Blood Pressure* | ☐ *Yes* ☐ *No* | |
| | *Recent Heart Attack / MI* | ☐ *Yes* ☐ *No* | |
| | *Artificial Heart Valve(s)* | ☐ *Yes* ☐ *No* | |
| | *Able to walk two flights of stairs* | ☐ *Yes* ☐ *No* | |
| **Lung** | *Shortness of breath (day or night)* | ☐ *Yes* ☐ *No* | |
| | *Asthma* | ☐ *Yes* ☐ *No* | |
| | *Sleep Apnea / Snoring* | ☐ *Yes* ☐ *No* | |
| | *Difficulty sleeping* | ☐ *Yes* ☐ *No* | |
| | *Lung problems* | ☐ *Yes* ☐ *No* | |
| | *Recent cold or cough* | ☐ *Yes* ☐ *No* | |
| **Skin** | *Masses / Bumps / Lumps* | ☐ *Yes* ☐ *No* | |
| | *Rashes* | ☐ *Yes* ☐ *No* | |
| | *Lesions/ Cuts /Scrapes* | ☐ *Yes* ☐ *No* | |
| | *Wounds / Blisters* | ☐ *Yes* ☐ *No* | |

| **REVIEW OF SYSTEMS Continued** | *Please review and check "no" or "yes" box* | | |
|---|---|---|---|
| | | **Any current problems with your health?** | **Comments – Additional information** |
| **Stomach / Gastrointestinal / Colon / Rectum** | *Stomach / Abdominal pain* | ☐ *Yes* ☐ *No* | |
| | *Hiatal hernia* | ☐ *Yes* ☐ *No* | |
| | *Heartburn / Indigestion* | ☐ *Yes* ☐ *No* | |
| | *Nausea / Vomiting* | ☐ *Yes* ☐ *No* | |
| | *Diarrhea* | ☐ *Yes* ☐ *No* | |
| | *Constipation* | ☐ *Yes* ☐ *No* | |
| | *Blood in Stool* | ☐ *Yes* ☐ *No* | |
| | *Jaundice / Yellowing of skin* | ☐ *Yes* ☐ *No* | |
| | *Hepatitis ☐A, ☐B, or ☐C* | ☐ *Yes* ☐ *No* | |
| **Muscles / Bones** | *Joint pain (where)* | ☐ *Yes* ☐ *No* | |
| | *Back pain /Disc disease* | ☐ *Yes* ☐ *No* | |
| | *Sprain / Strain* | ☐ *Yes* ☐ *No* | |
| | *Stiffness / Arthritis* | ☐ *Yes* ☐ *No* | |
| | *Artificial joint(s)* | ☐ *Yes* ☐ *No* | |
| | *Other physical disability* | ☐ *Yes* ☐ *No* | |
| **Urinary Tract** | *Urinary Problems* | ☐ *Yes* ☐ *No* | |
| | *Pain with urination* | ☐ *Yes* ☐ *No* | |
| | *Kidney Problems / Kidney Stones* | ☐ *Yes* ☐ *No* | |
| **Male / Female Issues Reproduction** | *Male or Female Specific Problems* | ☐ *Yes* ☐ *No* | |
| | ***Females** - Could you be pregnant?* | ☐ *Yes* ☐ *No* | |
| **Blood / Lymph** | *Bleeding problems* | ☐ *Yes* ☐ *No* | |
| | *Anemia* | ☐ *Yes* ☐ *No* | |
| | *Swollen or enlarged glands* | ☐ *Yes* ☐ *No* | |
| **Immunological** | *Hay fever* | ☐ *Yes* ☐ *No* | |
| | *Allergies* | ☐ *Yes* ☐ *No* | |
| | *HIV / Aids* | ☐ *Yes* ☐ *No* | |
| **Endocrine** | *Heat / Cold intolerance* | ☐ *Yes* ☐ *No* | |
| | *Hyperthyroid / Hypothyroid* | ☐ *Yes* ☐ *No* | |
| | *Increased thirst / Diabetes* | ☐ *Yes* ☐ *No* | |
| **Mental Health** | *Anxiety / Depression* | ☐ *Yes* ☐ *No* | |
| | *Psychiatric Care* | ☐ *Yes* ☐ *No* | |
| | *Other Concerns* | ☐ *Yes* ☐ *No* | |
| Patient Signature: | Date: | Provider Signature: | Date & Time: |

PLACE PATIENT LABEL HERE