



FOR OFFICE USE ONLY					
HPI: _____	ROS: _____	Past Medical Hx: _____	Family Hx: _____	Social Hx: _____	
BP: _____	Pulse: _____	Resp: _____	Height: _____	Weight: _____	

### PATIENT HEALTH HISTORY

Thank you for taking a few minutes to complete the following information about your personal health history. This information is extremely important to the doctor in determining current and future management of your health condition.

#### Patient Information

LAST NAME		FIRST NAME		MIDDLE		
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH  AGE	MARITAL STATUS (Please check one) <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED		RACE (Please check one) <input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK <input type="checkbox"/> HISPANIC <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> ALASKAN <input type="checkbox"/> OTHER <input type="checkbox"/> DECLINE		
Stated Height:		Stated Weight:		<input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed		
Occupation:			Employer:			
Student: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		School:				

Family or Primary Care Physician Name:	Phone:
--	--------

**Please list any other physician(s) you would like to receive information regarding your visit today:**

**CURRENT ILLNESS/CHIEF COMPLAINT:** Describe your current problem and symptoms (be specific and include body area).  
 \_\_\_\_\_  Right     Left  
 \_\_\_\_\_

When did you first notice the problem? \_\_\_\_\_

Does the problem interfere with your normal functions?     Yes     No

If yes, explain: \_\_\_\_\_

Do you have pain related to this problem?     Yes     No

If yes, please rate your pain on a scale of 1 to 10, 10 being the worst pain you can imagine:    # rating \_\_\_\_\_

Is this a work related injury:     Yes     No

If yes, how did the injury occur? \_\_\_\_\_

Have you had to stop working because of this problem?     Yes     No

Last day worked: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**PERSONAL MEDICAL HISTORY:** Please indicate whether you have had any of the following medical problems using dates. (e.g.  Anxiety disorder July 2006 - Present;  Stroke August 2008)

<input type="checkbox"/> Anxiety disorder _____	<input type="checkbox"/> Heart disease <input type="checkbox"/> Heart valve _____ <input type="checkbox"/> Aortic <input type="checkbox"/> Mitral	<input type="checkbox"/> Osteoporosis _____ Have you had a bone density test? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asthma/Lung disease/COPD _____	<input type="checkbox"/> Coronary artery _____ <input type="checkbox"/> Heart attack _____ <input type="checkbox"/> Other (list) _____	<input type="checkbox"/> Seizure disorder _____
<input type="checkbox"/> Bleeding tendencies _____	<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Sleep apnea _____
<input type="checkbox"/> Cancer (specify) _____ <input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Lung <input type="checkbox"/> Prostate <input type="checkbox"/> Other (list) _____	<input type="checkbox"/> High cholesterol _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Depression _____	<input type="checkbox"/> History of blood clots _____	<input type="checkbox"/> Thyroid problem _____
<input type="checkbox"/> Diabetes _____ <input type="checkbox"/> On insulin	<input type="checkbox"/> Kidney disease _____	<input type="checkbox"/> Other _____ (List) _____
	<input type="checkbox"/> Methicillin resistant staph infection (MSRA) _____	<input type="checkbox"/> None of the above
	<input type="checkbox"/> Other resistant bacterial infection _____	

**SURGICAL HISTORY:** Please list all prior operations including dates. (e.g.  Hernia repair March 2005)

<input type="checkbox"/> Abdominal aortic aneurysm _____	<input type="checkbox"/> Colon resection _____	<input type="checkbox"/> Kidney surgery _____
<input type="checkbox"/> Appendectomy _____	<input type="checkbox"/> C-section _____	<input type="checkbox"/> Leg artery bypass _____
<input type="checkbox"/> Bladder surgery _____	<input type="checkbox"/> Gall bladder removal _____	<input type="checkbox"/> Prostate surgery _____
<input type="checkbox"/> Carotid endarterectomy _____	<input type="checkbox"/> Hernia repair _____	<input type="checkbox"/> Tonsillectomy _____
<input type="checkbox"/> Carpal tunnel release _____	<input type="checkbox"/> Heart surgery (specify) _____ <input type="checkbox"/> Bypass <input type="checkbox"/> Valve Replacement	<input type="checkbox"/> Vein Stripping
<input type="checkbox"/> Eye surgery _____	Type _____	When _____
<input type="checkbox"/> Genitourinary surgery _____	Type _____	When _____
<input type="checkbox"/> Hip, knee or shoulder surgery _____	Type _____	When _____
<input type="checkbox"/> Nose/throat surgery _____	Type _____	When _____
<input type="checkbox"/> Oral surgery _____	Type _____	When _____
<input type="checkbox"/> Organ transplant _____	Section _____	When _____
<input type="checkbox"/> Plastic or hand surgery _____	Type _____	When _____
<input type="checkbox"/> Spine surgery _____	Type/Area _____	When _____
<input type="checkbox"/> Other _____	Type _____	When _____
<input type="checkbox"/> Other _____	Type _____	When _____
<input type="checkbox"/> Other _____	Type _____	When _____
<input type="checkbox"/> Any problem with anesthesia (e.g. malignant hyperthermia)		
<input type="checkbox"/> None of the above		

**SOCIAL HISTORY:**

**Tobacco Use:**

Cigarettes:  Never  Quit Date \_\_\_\_\_  Current Use: packs/day \_\_\_\_\_ # of years \_\_\_\_\_

Other Tobacco:  Pipe  Cigar  Snuff  Chew

Are you interested in quitting?  Yes  No

**Alcohol Use:**

Do you drink alcohol?  Yes  No # of drinks/week \_\_\_\_\_

Is your alcohol use a concern for you or for others?  Yes  No

**Drug Use:**

Do you use or have you used any recreational drugs?  Yes  No

Have you ever used needles to inject drugs?  Yes  No

**Sexual Activity:**

Are you sexually active?  Yes  No  Not currently

Birth control method: \_\_\_\_\_  None Needed

Have you ever had any sexually transmitted diseases (STDs)?  Yes  No

**Caffeine Intake:**  None  Coffee/Tea/Soda # of cups/day \_\_\_\_\_

**Weight:**

Are you satisfied with your weight?  Yes  No

**Diet:**

Are you on a special diet?  Yes  No

If yes, please describe: \_\_\_\_\_

**Exercise:**

Do you exercise regularly?  Yes  No

If yes, how long (minutes)? \_\_\_\_\_ How often: \_\_\_\_\_

What type of exercise? \_\_\_\_\_

If you do not exercise, why? \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**FAMILY HISTORY:** Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions.

<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Emphysema _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Birth Defects _____	Was diagnosis before age 65? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>List type:</i> _____	<input type="checkbox"/> High blood pressure _____
<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Blood Disorders _____	<input type="checkbox"/> Liver Disease _____
<i>List type:</i> _____	<input type="checkbox"/> Lung Disease _____
<input type="checkbox"/> Bone Disease/Osteoporosis _____	<input type="checkbox"/> Multiple Sclerosis _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Nervous Disorders _____
<i>List type:</i> _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Cerebral Palsy _____	<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/> Chronic Bronchitis _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic Fibrosis _____	<i>Specify:</i> _____
	<input type="checkbox"/> None of the above

**REVIEW OF SYSTEMS:** Please check any current symptoms you have.

**Cardiovascular**

- Slow heart rate
- Chest pain
- Palpitations
- Swelling of ankles
- Fainting
- Fast heart rate
- Other
- None of the above

**Constitutional**

- Chills
- Decreased activity
- Fatigue
- Fever
- Sweats
- Weakness
- Other
- None of the above

**Endocrine**

- Cold intolerance
- Excessive hunger
- Excessive thirst
- Heat tolerance
- Frequent urination
- Other
- None of the above

**ENMT**

- Decreased hearing
- Ear pain
- Nasal congestion
- Sore throat
- Other
- None of the above

**Eye**

- Blurring
- Discharge
- Double vision
- Yellowing of eyes
- Recent visual problems
- Visual disturbances
- Other
- None of the above

**Gastrointestinal**

- Abdominal pain
- Constipation
- Diarrhea
- Heartburn
- Vomiting blood
- Nausea
- Vomiting
- Loss of control
- Other
- None of the above

**Genitourinary**

- Change in urine stream
- Painful urination
- Blood in urine
- Lesions or sores on genitals
- Urethral discharge
- Loss of control
- Other
- None of the above

**Hema/Lymph**

- Bleeding tendency
- Bruises
- Bruising tendency
- Bleeding problems
- Petechiae (small bruises)
- Swollen lymph glands
- Other
- None of the above

**Immunologic**

- Malaise (Fatigue)
- Other
- None of the above

**Integumentary**

- Skin abrasions
- Skin breakdown
- Burns
- Dry skin
- Petechiae (small bruises)
- Itching
- Rash
- Skin lesion
- Other
- None of the above

**Musculoskeletal**

- Back pain
- Pain in legs with walking
- Decreased range of motion
- Joint pain
- Muscle pain
- Trauma
- Other
- None of the above

**Neurologic**

- Abnormal balance
- Confusion
- Headache
- Numbness
- Tingling
- Other
- None of the above

**Psychiatric**

- Anxiety
- Delusional
- Depression
- Hallucinations
- Mania
- Suicidal
- Other
- None of the above

**Respiratory**

- Episodes of not breathing
- Cough
- Blue color to skin
- Coughing up blood
- Shortness of breath
- Coughing up phlegm
- Wheezing
- Other
- None of the above

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Is there anything not included in this form that you want your doctor to know about you?

---

---

---

---

---

---

---

---

---

---

I certify the information on this form is true to the best of my knowledge.

\_\_\_\_\_  
**Patient/Parent/Authorized Person Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Relationship to Patient**

M.D. Reviewed: \_\_\_\_\_

Date: \_\_\_\_\_

M.D. Reviewed: \_\_\_\_\_

Date: \_\_\_\_\_

M.D. Reviewed: \_\_\_\_\_

Date: \_\_\_\_\_

M.D. Reviewed: \_\_\_\_\_

Date: \_\_\_\_\_