Patient Label Here

Patient Health History Form- NEW PATIENT

Patient Name:				Today's date:
Gender	☐ Male ☐ Female	**Birth date** (mm/dd/yy):		
Currently Living:	☐ Alone	☐ With family	☐ With friends	☐ With significant other
Profession (Job):	☐ Currently working	☐ Not currently working		☐ Retired

Personal Health History

Constitutional	**No**	**Yes, Now**	**Yes, Past**	**Eye(s)**	**No**	**Yes, Now**	**Yes, Past**
Difficulty sleeping				Cataracts			
Tiredness or Weakness				Glaucoma			
Forgetfulness				**Ears, Nose &/or Throat**			
Abnormal weight loss or gain				Ear infections			
Alcohol or Chemical dependence				Sinus problems			
Respiratory				Deafness, Dizzy or Ringing			
Tuberculosis or Positive TB test				**Cardiovascular**			
Shortness of breath				Abnormal EKG			
Bronchitis, COPD or Emphysema				Heart attack or Heart disease			
Asthma				Mitral valve prolapse			
Cough (persistent or bloody)				Heart murmur			
Neurological				High blood pressure			
Headaches (frequent)				High cholesterol			
Epilepsy or Seizures				Chest pain			
Head injury				Circulatory problems			
Gastrointestinal				Phlebitis or Blood clots			
Gall stones				Stroke			
Stool or Bowel problems				Rheumatic fever			
Stomach problems or Ulcers				**Genitourinary**			
Liver disease				Kidney or Bladder problems			
Jaundice				**Musculoskeletal**			
Hemorrhoid or Rectal problem				Arthritis or Sore joints			
Hepatitis				Hernia			
Skin				Broken bones			
Psoriasis or Eczema				Gout			
Immunology				**Psychological**			
HIV/ AIDS				Depression and Sadness			
Hematological/ Allergy				Anxiety			
Cancer				Psychiatric care			
Anemia				**Endocrine**			
Bleeding or Bruising				Diabetes			
Hay fever				Thyroid disease			

Pain or lumps in testicle(s)? ☐Yes ☐No ☐N/A
Prostate disease or problems? ☐Yes ☐No ☐N/A
Last prostate exam:_____ Abnormal? ☐Yes ☐No ☐N/A
Problems start/stop urine stream? ☐Yes ☐No ☐N/A
Wake while sleeping to urinate? ☐Yes ☐No ☐N/A
Sexual problems or concerns? ☐Yes ☐No ☐N/A
History of STD(s)/venereal disease? ☐Yes ☐No ☐N/A
Are you unsafe during intercourse? ☐Yes ☐No ☐N/A

Last colonoscopy:_______ Abnormal? ☐Yes ☐No ☐N/A
Last pap smear:________ Abnormal? ☐Yes ☐No ☐N/A
Last mammogram:_______ Abnormal? ☐Yes ☐No ☐N/A
Age periods started:_____ Problems? ☐Yes ☐No ☐N/A
Ovarian cysts? ☐Yes ☐No ☐N/A
Birth control method: ______________________________
Pregnancies: # __________ Births: # __________
Do you have a living will? ☐Yes ☐No
Do you feel safe in your home? ☐Yes ☐No

Please turn over and complete other side

What is our main focus for today's visit? ____

____

____

____

Habits			
Do you…			**If yes, how much?**
Use cigarettes?	☐ Yes	☐ No	____________
Chew tobacco?	☐ Yes	☐ No	____________
Drink caffeine?	☐ Yes	☐ No	____________
Drink alcohol?	☐ Yes	☐ No	____________
Use street drugs?	☐ Yes	☐ No	____________
Exercise Frequency: ____________ X per week			

Medications
List all medications, include non-prescription:
1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

Immunizations		
All appropriate-to-age immunizations completed		☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Date:
Tetanus	☐ Yes ☐ No	Date:
Influenza	☐ Yes ☐ No	Date:
Shingles	☐ Yes ☐ No	Date:

Allergies
List all allergies (including medicine, food, latex, etc.)

Hospitalizations (not including pregnancies)	
Reason:	Year:
Reason:	Year:
Reason:	Year:
Reason:	Year:

Surgeries	
Surgery:	Year:
Surgery:	Year:
Surgery:	Year:
Surgery:	Year:
Surgery:	Year:
Surgery:	Year:
Surgery:	Year:

Family History

Disease		Relationship	Disease		Relationship
Alcoholism	☐ Yes ☐ No		Eye disease(s)	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No		Heart attack	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No		High blood pressure	☐ Yes ☐ No	
Birth defects	☐ Yes ☐ No		Kidney disease	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No		Mental illness	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No		Migraines	☐ Yes ☐ No	
Epilepsy	☐ Yes ☐ No		Stroke	☐ Yes ☐ No	
Other:	☐ Yes ☐ No		Other:	☐ Yes ☐ No	

The information on this Patient Health History form is correct to the best of my knowledge.

Patient or Guardian Signature: ______________________________ Date: ______________

Provider Acknowledges Review of this form Provider: ____________ Date: ____________