 Patient Label Here

**Patient Health History Form- NEW PATIENT**

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| **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 |

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| **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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Habits** | **Medications** |
| **Do you…** | **If yes, how much?** | **List all medications, include non-prescription:** |
| Use cigarettes? |  Yes  No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Chew tobacco? |  Yes  No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Drink caffeine? |  Yes  No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Drink alcohol? |  Yes  No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Use street drugs? |  Yes  No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Exercise Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X per week | 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Immunizations** | **Allergies** |
| All appropriate-to-age immunizations completed |  Yes  No | List all allergies (including medicine, food, latex, etc.) |
| Pneumonia |  Yes  No | Date: |  |
| Tetanus |  Yes  No | Date: |  |
| Influenza |  Yes  No | Date: |  |
| Shingles |  Yes  No | Date: |  |

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

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| **Surgeries** |
| Surgery: | Year: |
| Surgery: | Year: |
| Surgery: | Year: |
| Surgery: | Year: |
| Surgery: | Year: |
| Surgery: | Year: |
| Surgery: | Year: |

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_