Bair Bones Osteopathic
Family Medicine Inc

Date:____________

Health History

This form lets us get to know you, and how we can best offer our help. Please take your time and answer as best as you can. The more you tell us about yourself, the more information we'll have to personalize your care. If there is a question that makes you uncomfortable, skip it and we can discuss it during your visit.

Preferred Name:____

Complete name on identity documents (if different): ____________________________________

Date of Birth:_______________________ Age:_________________ Phone:________________

Referred by/Heard of us from:____

Current/Previous Primary Care Provider:_____________________________ Phone:____________

Goals for today's visit/Current health concerns (in order of importance):

1.____

2.____

3.____

◻ I have more than 3 concerns to address. *Additional visits may be necessary to address all concerns.*

Medical History: Please mark all current or previous medical conditions. ◻ None

◻ Acid reflux
◻ Asthma
◻ Alcohol/Drug addiction
◻ Allergies
◻ Anxiety
◻ Arthritis
◻ Autoimmune disease
◻ Back pain
◻ Breast mass
◻ Black/bloody stool
◻ Blood disease/clots
◻ Cancer
◻ Chest pain
◻ Chronic cough
◻ Chronic pain
◻ Colitis
◻ Colon cancer
◻ COPD
◻ Constipation
◻ Depression
◻ Diabetes
◻ Difficult urination
◻ Diverticulitis
◻ Epilepsy/Seizures
◻ Frequent Diarrhea
◻ Frequent urination
◻ Gastritis/Stomach ulcer
◻ Gallbladder problems
◻ Hernia
◻ Heart problems
◻ Hepatitis
◻ High blood pressure
◻ High cholesterol
◻ HIV
◻ Kidney stones
◻ Kidney problems
◻ Liver problems
◻ MRSA/Abscesses
◻ Pancreatitis
◻ Severe headaches
◻ Stroke
◻ Thyroid problems
◻ Tuberculosis
◻ Urinary incontinence
◻ Vertigo
◻ Other/Notes:_________
____
____
____

Allergies (include medications, foods, environmental triggers, and type of allergic reaction): ◻ None

____

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Current Medications/Supplements (name, dosage, frequency): ☐ None ☐ I frequently miss medication doses.
☐ I have difficulty affording my prescriptions. ____

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____

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____

What surgeries have you had in the past?: ☐ None ____

____

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Review of Systems: Mark all new or bothersome symptoms you've had in the past month. ☐ None

-General-
☐ Weight loss or gain
☐ Fatigue
☐ Fever or chills
☐ Generalized weakness

-Skin-
☐ Rash
☐ Itching
☐ Dry skin

-Head-
☐ Headache
☐ Head injury
☐ Jaw pain

-Ears-
☐ Ringing in ears
☐ Earache

-Eyes-
☐ Vision Loss/Changes
☐ Eye pain/Redness

-Nose-
☐ Frequent congestion/runny nose
☐ Nosebleeds
☐ Sinus pain

-Mouth/Throat-
☐ Mouth/throat pain
☐ Bleeding gums
☐ Dry mouth

-Neck-
☐ Swollen glands
☐ Pain

-Chest/Breasts-
☐ Lumps
☐ Pain
☐ Nipple discharge

-Respiratory-
☐ Chronic cough
☐ Coughing up sputum/blood
☐ Shortness of breath

-Cardiovascular-
☐ Chest pain or discomfort
☐ Rapid or irregular heart beat
☐ Leg/hand/face swelling

-Gastrointestinal-
☐ Heartburn
☐ Change in appetite
☐ Nausea/vomiting
☐ Change in bowel habits
☐ Constipation
☐ Diarrhea
☐ Yellow eyes or skin

-Genitourinary-
☐ Genital pain/skin symptoms
☐ Abnormal genital discharge
☐ Genital/groin itching
☐ Abnormal menstrual cycle
☐ Frequent urination
☐ Pain or bleeding with urination

-Vascular-
☐ Leg cramping
☐ Painful or swollen veins

-Musculoskeletal-
☐ Muscle or joint pain/swelling
☐ Stiffness
☐ Back pain

-Neurologic-
☐ Dizziness
☐ Fainting
☐ Seizure
☐ Weakness
☐ Numbness/Tingling
☐ Tremor

-Hematologic-
☐ Bruise easily
☐ Abnormal bleeding

-Endocrine-
☐ Heat or cold intolerance
☐ Frequent/heavy sweating
☐ Increased thirst
☐ Hair and nail changes

-Psychiatric-
☐ Anxiety/Agitation
☐ Depression
☐ Memory loss
☐ Compulsive behavior
☐ Racing thoughts
☐ Severe mood swings
☐ Suicidal thoughts/attempts

*-Other/Notes:*____________

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continued...↺

Have any of your relatives had any of the following?: ☐ None ☐ Adopted/without family health information

☐ Alcohol/Drug addiction
☐ Alzheimer's disease
☐ Autoimmune disease
☐ Blood disease/blood clots
☐ Breast cancer
☐ Colon cancer
☐ Diabetes
☐ Heart problems
☐ High cholesterol
☐ High blood pressure
☐ Mental illness
☐ Ovarian/Uterine Cancer
☐ Parkinson's disease
☐ Prostate cancer
☐ Other/Notes:__________
____
____

Social History (mark/complete all that apply):

☐ Alcohol: ☐ Beer ☐ Wine ☐ Liquor ☐ I want to drink less
☐ Tobacco: ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco ☐ I DO want to quit ☐ I DON'T want to quit
☐ Illicit drugs: Type(s)____
☐ Sweetened beverages: Type____________________________Amount/wk___________________
☐ Exercise: Type____ Avg minutes/wk___________
☐ Occupation: ____
☐ If sexually active, please list any medications, devices, or behaviors you currently use to prevent pregnancy and/or sexually transmitted infections____

FOR PRIMARY CARE PATIENTS ONLY:

☐ Please list your most recent cancer screenings, when and where you had them, and if they were normal or not. Include pap smears, HPV testing, mammograms, colonoscopies, prostate testing, or any biopsies. ☐ None ____
____
____
☐ When did you last have lab work done? Where? ____________________________________
☐ Would you like to be tested for sexually transmitted infections (gonorrhea, chlamydia, trichomoniasis, HIV, syphilis)? ☐ YES ☐ NO
☐ If you menstruate, when was the first day of your last menstrual period? ____________________
☐ If you used to menstruate, but no longer do, when did you stop?___________________________
☐ Would you like to discuss contraceptive options? ☐ YES ☐ NO
☐ If you have been pregnant and/or given birth, how many times?__________________________

Patient Name:

Signature of Responsible Party: Date:

Printed name and relationship of Responsible Party if not "Self" (e.g. mother, guardian, etc.):