

Patient Health History

Patient Name: _____ **Date:** _____

Medical Conditions: (Check all that apply to you, currently or in the past)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Diabetes (Type 1 or 2) | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autoimmune disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Other _____ | | | |

Surgeries: (Check all that apply to you)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Appendix removal | <input type="checkbox"/> Gallbladder removal | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> C-section |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Ovary Removal/Tubal | <input type="checkbox"/> Spine surgery | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> Shoulder | <input type="checkbox"/> Heart (CABG, Valves, etc) | <input type="checkbox"/> Cataract surgery | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Other Joints: _____ | <input type="checkbox"/> Cardiac stents | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Colon surgery |
| <input type="checkbox"/> Tonsils/Adenoid removal | <input type="checkbox"/> Sinus <input type="checkbox"/> Brain | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Thyroid surgery |
| Others _____ | | | |

Allergies: (Medications/Food/Environmental) _____

Social History: (Check all that apply to you)

<u>Substance</u>	<u>Current</u>	<u>Former</u>	<u>Never</u>	<u>Substance</u>	<u>Current</u>	<u>Former</u>	<u>Never</u>
Caffeine use:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaping/E-cigarettes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol use:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marijuana:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarette/Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Drugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If current or former, please specify type/amount/frequency: _____

Family History: (Check all that apply) Unknown / Adopted

<u>Condition</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling(s)</u>	<u>Condition</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling(s)</u>
Heart Disease / MI:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (Any type):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health disorder:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dementia/Alzheimer's:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

PHARMACY: _____

Medications: List all medications you are currently taking. 1) _____

2) _____ 3) _____

4) _____ 5) _____

6) _____ 7) _____

Patient Name: _____ Date: _____

Review of Systems – (Check the box if you *are having* trouble with any of the following)

<p>General/Constitutional</p> <p><input type="checkbox"/> Chills <input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Fatigue/Low Energy <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Fever <input type="checkbox"/> Other: _____</p>	<p>Musculoskeletal</p> <p><input type="checkbox"/> Broken Bones <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Painful/Stiff Joints <input type="checkbox"/> Back/Neck Pain <input type="checkbox"/> Weakness <input type="checkbox"/> Other: _____</p>
<p>HEENT</p> <p><input type="checkbox"/> Hearing loss <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sinus pressure <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Visual changes <input type="checkbox"/> Blurry/Double Vision <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Other: _____</p>	<p>Integumentary</p> <p><input type="checkbox"/> Breast discharge <input type="checkbox"/> Breast lump <input type="checkbox"/> Hives <input type="checkbox"/> Mole change(s) <input type="checkbox"/> Rash <input type="checkbox"/> Skin lesion <input type="checkbox"/> Poor Healing <input type="checkbox"/> Other: _____</p>
<p>Endocrine</p> <p><input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Other: _____</p>	<p>Respiratory</p> <p><input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Chest Pain <input type="checkbox"/> Other: _____</p>
<p>Metabolic/Endocrine</p> <p><input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Menstrual Cycle Change <input type="checkbox"/> Hair Loss <input type="checkbox"/> Other: _____</p>	<p>Gastrointestinal</p> <p><input type="checkbox"/> Abdominal pain <input type="checkbox"/> Blood in stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Other: _____</p>
<p>Cardiovascular</p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Edema <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg Swelling <input type="checkbox"/> Left Arm Pain <input type="checkbox"/> Other: _____</p>	<p>Neurologic</p> <p><input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Extremity numbness <input type="checkbox"/> Headaches <input type="checkbox"/> Extremity weakness <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Other: _____</p>
<p>Psychiatry</p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Stress <input type="checkbox"/> Other: _____</p>	<p>Genitourinary</p> <p><input type="checkbox"/> Blood in Urine <input type="checkbox"/> Painful Urination <input type="checkbox"/> Urinary Frequency <input type="checkbox"/> Other: _____</p>
<p>Hematologic</p> <p><input type="checkbox"/> Easily bleeds <input type="checkbox"/> Easily bruises <input type="checkbox"/> Lymphedema <input type="checkbox"/> Issues with blood clots <input type="checkbox"/> Other: _____</p>	<p>Immunologic</p> <p><input type="checkbox"/> Food allergies <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Other: _____</p>

Women: Are you Pregnant? Yes No If so, how many weeks: _____

Anything else you would like to talk about that was not covered above: _____