HEALTH HISTORY

Full Name:

How would you prefer to be addressed? (Mr./Ms., nickname, etc.):

Address:

Preferred Phone Number:

Is it okay to leave a detailed message on this number? Yes No

Birthday:

Insurance Name:

Insurance ID & Group Number, Effective Date:

Preferred Email:

Emergency Contact Name/Phone Number/relationship:

Preferred Local Hospital System:

Pharmacy Name:

Number/Fax:

Address/Location:

Height:

Usual Weight:

INTRODUCTION: How did you learn about our office? What are your goals for your first visit? How would you describe your health? What are your health goals?

MEDICATIONS: Please list all prescription and nonprescription (over the counter) medications, as well as any supplements. Okay to include on a separate sheet of paper if you have a pre-printed list.

Name	Dose (mg or ?)	How often (daily, twice daily?)	For what?

PAST MEDICATIONS: Are there any medications you have taken in the past? Why were they stopped?

ALLERGIES: Please list all medication allergies, including your reaction. Also list any food or environmental allergies.

PRESENT CONCERN(S): What is your most concerning health problem? What measures have you taken so far to address it (treatments, medications, specialists seen).

REVIEW OF SYSTEMS: Please list any symptoms that bother you, from head to toe. For example – dry eyes, skin rash on arm, heartburn after meals, back pain etc.)

GENERAL (Weight, sleep energy level etc.):

SKIN:

HEAD, NECK:

EARS, EYES, THROAT:

RESPIRATORY:

CARDIAC/HEART:

GASTROINTESTINAL:

GENITAL/URINARY:

MUSCULOSKELETAL (back, limbs, joints, muscles):

NEUROLOGIC:

PSYCHIATRIC:

OTHER:

MEDICAL HISTORY: Please list all medical problems, including conditions that have resolved or are controlled with medications (i.e. high blood pressure). Please include the approximate date it began. Examples may include: high cholesterol, diabetes, cancer, heart attack, stroke, etc.

SURGICAL HISTORY: Please list surgeries you have had, their approximate date, hospital, and name of the surgeon.

HOSPITALIZATIONS: Please list any times other than surgery you have stayed overnight in the hospital, the date, reason, and which hospital.

REPRODUCTIVE HEALTH HISTORY:

Do you have children? (If you had/have female organs, at what age did you begin periods?

Describe their frequency and any related symptoms.

Have you had pregnancies/abortions/miscarriages?

If you had/have male organs, have you had any penile/testicular conditions?)

All sexes: Are you currently sexually active? Do you take any steps to prevent pregnancy or disease?

SOCIAL HISTORY:

Where you were born?

Where did you grow up?

What is your family race/ethnicity background?

Your first language?

How much schooling (high school, college, grad school)?

Your relationship or marriage history?

Do you have children, and if so what are their ages?

What type of work have you done or do you do?

Describe what you do in your free time.

Do you have a spiritual or religious practice?

Is there a specific clergy person you would want to be involved in or aware of your care if you were hospitalized?

RECREATIONAL DRUG USE:

Do you smoke (how many packs per day, year started & year quit)?

How much alcohol do you drink per day or week now and in the past & types?

Do you use, or have you used, marijuana for recreation or medicinal purposes?

Have you used any other types of recreational/illicit drugs?

Alcohol:

Tobacco:

Other:

PSYCHIATRIC HISTORY:

What are your stressors?

What do you do to relieve stress?

Do you feel depressed or anxious?

Have you ever been formally diagnosed with any condition, or been in the care of a psychiatrist in a clinic or in the hospital?

SEXUAL HEALTH HISTORY:

Do you have any question or concern about your gender identity?

In your intimate relationships, do you favor partners who are male, female, or those who might identify otherwise?

Do you have any questions about your sexual health?

Do you think you are at risk for HIV?

DIET: What kinds of foods do you usually eat for breakfast, lunch, or dinner. Can you eat all consistency foods? Do you take any nutrition supplements? Are there any specific foods you avoid, and if so, why?

ACTIVITY: What kinds of exercise or physical activity to you do? How often and for how long (duration)?

FAMILY HISTORY: Please note your first-degree family members (parent, sibling, child) and any health conditions they have/had. Also note if there are any health conditions which have occurred in multiple family members (cousins, aunts, uncles, grandparents). Examples: Cancer (what kind?), heart attack, stroke, high blood pressure, diabetes, high cholesterol, blood disorders, anxiety/depression/bipolar, etc.

Mother:

Father:

Sister:

Brother:

Maternal grandmother:

Maternal grandfather:

Paternal grandmother:

Paternal grandfather:

Child/children:

HEALTH MAINTENANCE: Please not if you have or have not had the following tests, and the approximate date:

Eye Exam
Dental Exam
Hearing Exam
EKG
Colonoscopy
Flu Shot
Tetanus shot
Pneumonia shot
Shingles shot
Mammogram (females)
Pap Smear (females)
PSA (prostate lab test) (males)
Sleep study
Pulmonary Function Test
Echocardiogram

SAFETY CONCERNS:

Do you always wear a seat belt when you drive? Yes No

Do you always wear a bike helmet? Yes No

Do you think you are at risk of HIV or sexually transmitted disease? Yes No

Do you keep firearms in your home? Yes No

If so, are they stored in a locked place? Yes No

Do you have working smoke detectors?

Do you have a working carbon monoxide detector?

Do you feel safe in your neighborhood? Yes No

Is there anyone in your life now who says abusive things to you or has physically harmed you? Yes No

Is there anyone in your past who said abusive things to you or physically harmed you? Yes No

Is there anyone using your money without your permission? Yes No

Do you have problems with walking or falls? Yes No

Do you or anyone in your life have concerns about your driving safely? Yes No

EXPOSURE HISTORY: Have you ever been exposed to chemicals, irritants, or pollutants in the past? Examples: Lead-based paint, water-damaged building with mold, living in an area exposed to pesticides or radiation, or working in a place with chemicals, animals, or radiation.

FUNCTIONAL HISTORY: Do you need help with any of the following: transferring from a bed to a chair, walking, or travelling by car; upper or lower body dressing or bathing; buying food, making meals, or feeding yourself; managing your medications or finances? Do you have any problems with bowel or bladder continence? Do you use any medical equipment at home (CPAP machine, oxygen, walker, glucometer, etc.)?

ADVANCE DIRECTIVES: Please list who you would want called in the event of an emergency. Also list who you would want to make decisions for you if you are unable to speak for yourself. Do you have an advance directive? If so, please bring a copy for your electronic medical record. This can be submitted electronically by email or by paper for scanning into your record.

CARE PROVIDERS: Please list any medical/healthcare professionals involved in your care, including doctors, dentists, eye doctors, massage therapists, chiropractors, specialists, etc. (Please include a phone number and fax number when possible.)

Please list the name and phone number of any other individual(s) who you wish to be allowed access to your health information in the event of serious health condition, such as a trusted close friend or first-degree family members. Indicate their relationship to you.