Patient Health History

Name: _____ Date of Birth: _____ Age: _____

SS #: _____ Today's Date: _____ Sex: Male ☐ Height: _____

Gender Identity: Female ☐

☐ Man ☐ Woman ☐ Transgender Male (man) ☐ Transgender female (woman) ☐ Genderqueer/Non-binary ☐ Choose not to disclose

Pronouns: ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other ☐ Choose not to disclose

Religious preference (ex. Christianity, Islam, Judaism, etc.): _____ ☐ Choose not to disclose

Primary Care Physician: _____ Phone Number: _____

Referring MD: _____ Phone Number: _____

Other MD's (Name/Specialty): _____ Phone Number: _____

Behavioral Health Provider: _____

Pharmacy Name: _____ Pharmacy Number: _____

Current problem or reason for consultation: _____

PAST MEDICAL HISTORY: *Please check all the boxes that apply*

Allergies	☐	Hepatitis/Liver Disease	☐
Anemia/Blood Disorders	☐	Hypercholesterolemia	☐
Arthritis	☐	Hypertension	☐
Asthma	☐	Irregular Heartbeat	☐
Blood Clots	☐	Kidney Disease	☐
Cancer	☐	Pancreatitis	☐
Cataracts	☐	Sickle Cell Disease	☐
Colitis	☐	Sinusitis	☐
Diabetes	☐	Stroke	☐
Emphysema	☐	Thyroid	☐
GERD	☐	Tuberculosis	☐
Glaucoma	☐	Ulcers	☐
Heart Disease	☐		

Other: _____

Other: _____

Any unusual childhood infections or illnesses? _____

OPERATIONS: *Please list year, operation and surgeon (if known)*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ROUTINE CANCER SCREENING TESTS:

Mammogram: _____

Breast Exam: _____

Pap Smear/Pelvic Exam: _____

Stool for Occult Blood: _____

Prostate Exam/PSA: _____

Chest X-Ray: _____

Colonoscopy/Sigmoidoscopy: _____

ALLERGIES TO MEDICATIONS: Yes ☐
No ☐

NAME OF DRUG(S)/TYPE OF REACTION:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS AND NUTRITIONAL SUPPLEMENTS:

NAME OF DRUG	DOSE (mg or mcg)	HOW MANY TIMES DAILY	HOW LONG (MONTH/YEARS)

Vaccinations (Please provide date of last vaccination):

Pneumonia
1st shot: _____
2nd shot: _____

Shingles
1st shot: _____
2nd shot: _____

COVID Vaccine
☐ J & J
☐ Moderna
☐ Pfizer

1st shot: _____
2nd shot: _____
3rd shot: _____

Influenza: _____

FAMILY HISTORY:

Relative	Age, If Living	Health Problems	If Deceased, list cause
Father			
Mother			
Sis/Bro			
Sis/Bro			
Sis/Bro			
Sis/Bro			
Sis/Bro			

For other relatives such as grandparents, aunts and uncles: *Please check all boxes that apply*

Anemia	☐	Diabetes	☐
Blood Clots	☐	Heart Disease	☐
Blood Disorders	☐	Hypertension	☐
Cancer	☐	Stroke	☐

Approximately 10% of cancer is hereditary. If you are concerned your family may be at risk, genetic counseling may be appropriate for you.

Would you like to discuss this with your physician? Yes ☐ No ☐

REVIEW OF SYSTEMS: *Please check all boxes that apply*

GENERAL	FEVER	☐	WEIGHT LOSS	☐	FATIGUE	☐
	CHILLS	☐	WEIGHT GAIN	☐	NIGHT SWEATS	☐
HEAD	HEADACHES	☐	RINGING IN EARS	☐	TOOTHACHE	☐
	BLACKOUTS	☐	SINUSITIS	☐	DOUBLE VISION	☐
	SEIZURES	☐	POST NASAL DRIP	☐	BLURRED VISION	☐
	DIZZINESS	☐	SORE THROAT	☐	CATARACTS	☐
	HEARING LOSS	☐	HOARSENESS	☐	GLAUCOMA	☐
	EARACHE	☐	SORE TONGUE	☐	LAST EYE EXAM_____	
	BLEEDING GUMS	☐	NOSEBLEEDS	☐		
CHEST	COUGH	☐	SHORTNESS OF BREATH	☐	HEART MURMUR	☐
	SPUTUM	☐	CHEST PAIN	☐	RHEUMATIC FEVER	☐
	COUGHING UP BLOOD	☐	PALPITATIONS	☐	HIGH BLOOD PRESSURE	☐
	WHEEZING	☐	SWELLING OF FEET	☐	LAST CHEST X-RAY _____	
	BRONCHITIS	☐	ASTHMA	☐		
NECK	LUMPS	☐	GOITER	☐	PAIN OR STIFFNESS	☐
BREAST	LUMPS	☐	PAIN	☐	NIPPLE DISCHARGE	☐
ABDOMEN	NAUSEA	☐	ABDOMINAL PAIN	☐	CONSTIPATION	☐
	VOMITING	☐	HIATAL HERNIA	☐	DIARRHEA	☐
	PAIN WHEN SWALLOWING	☐	ULCER	☐	HEMORRHOIDS	☐
	DIFFICULTY SWALLOWING	☐	GAS	☐	BLOOD IN STOOLS	☐
	INDIGESTION	☐	BLOATING	☐	BLACK STOOLS	☐

CONTINUE REVIEW OF SYSTEMS: *Please check all boxes that apply*

URINARY/GYN	BLOOD IN URINE	☐	# OF PREGNANCIES _____				
	BURNING WITH URINATION	☐	# OF MISCARRIAGES _____		SPOTTING	☐	
	FREQUENT URINATION	☐	# OF ABORTIONS _____		CRAMPING	☐	
	DIFFICULTY STARTING TO URINATE	☐	# OF CHILDREN _____		DISCHARGE	☐	
	BLADDER/ KIDNEY INFECTIONS	☐	LAST MENSTRUAL PERIOD _____		VAGINAL INFECTIONS	☐	
	GETTING UP AT NIGHT TO URINATE	☐	DURATION _____		LAST PAP SMEAR _____		
	SENSE OF FULL BLADDER	☐	INTERVAL _____				
SKIN	RASH	☐	ITCHING	☐	CHANGE IN HAIR OR NAILS	☐	
NEURO-MUSCULAR	JOINT STIFFNESS	☐	SWELLING	☐	NIGHT CRAMPS	☐	
	JOINT PAIN	☐	BACK PAIN	☐	VARICOSE VEINS	☐	
HEMATOLOGICAL	EASY BRUISING OR BLEEDING	☐	ANEMIA	☐	PAST INFUSION	☐	
					TRANSFUSION REACTIONS	☐	
ENDOCRINE	THYROID PROBLEMS	☐	HOT OR COLD INTOLERANCE	☐	EXCESSIVE THIRST OR HUNGER	☐	
PSYCHIATRIC	ANXIETY	☐	DEPRESSION	☐	MEMORY LOSS	☐	
	PANIC ATTACKS	☐	SUICIDAL THOUGHTS	☐	INSOMNIA	☐	

SOCIAL HISTORY:

Sexual Orientation: ☐ Heterosexual ☐ Bisexual ☐ Lesbian or gay ☐ Chose not to disclose

Other (please describe):

Marital Status: _____

Number of Children: _____ Age/Sex of Children: _____

Are you or could you currently be pregnant? ☐ Yes ☐ No ☐ N/A

Do you plan on having children in the future ? ☐ Yes ☐ No ☐ N/A

Would you like to discuss fertility preservation? ☐ Yes ☐ No ☐ N/A

Spouse Name: _____

Spouse Occupation: _____

Patient Occupation: _____

Highest Level of Education: _____

Patient Lives With: Self ☐ Child ☐
Spouse ☐ Parent(s) ☐
Sibling(s) ☐ Friend ☐
Other ☐ _____

Smoking History

Cigarettes ☐ How Many Years?_____
Cigars ☐ Number Per Day _____
Pipe ☐ If Quit, When? _____

Alcohol History

Beer ☐ How Many Years?_____
Wine ☐ How Much Per Day/Week/Month? _____
Liquor ☐ If Quit, When? _____

Recreational Drug Use ☐ Blood Transfusions ☐ HIV Testing ☐
Marijuana ☐ Do you have a medical marijuana card? ☐ YES ☐ NO
If so, who is your prescriber? _____

SUPPORT SERVICES:

Have you completed an advance directive? ☐ YES ☐ NO

Have you completed a living will? ☐ YES ☐ NO

Have you completed a medical power of attorney? ☐ YES ☐ NO

Do you have a need that you would like to discuss with a social worker? ☐ YES ☐ NO

Do you forsee TRANSPORTATION to be an issue when going to and from appointments? ☐ YES ☐ NO

Do you have financial concerns that you would like to discuss with a patient benefits representative? ☐ YES ☐ NO

PATIENT SIGNATURE: _____

PHYSICIAN SIGNATURE: _____