Patient Health History

Name: _____ Date of Birth: _____ Age: _____

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

Gender Identity: Female ☐

☐ Male ☐ Female ☐ Transgender Male (man) ☐ Transgender female (woman) ☐ Genderqueer/Non-binary ☐ Chose not to disclose

Preferred pronoun (ex. he/him/they, she/her/they, they) _____ Other (please describe below):

_____

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

Primary Care Physician: _____ Phone Number: _____

Referring MD: _____ Phone Number: _____

Other MD's: Name/Specialty _____

Pharmacy Name: _____ Pharmacy Number: _____

Current problem or reason for consultation: _____

Do you feel you need to be linked to our social worker (counseling or financial issues)? Yes ☐ No ☐

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. _____

ROUTINE CANCER SCREENING TESTS: *List last date (if known)*

Mammogram: _____

Breast Exam: _____

Pap Smear/Pelvic Exam: _____

Stool for Occult Blood: _____

Prostate Exam/PSA: _____

Chest X-Ray: _____

Colonoscopy/Sigmoidoscopy: _____

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: _____

Spouse Name: _____

Spouse Occupation: _____

Patient Occupation: _____

Highest Level of Education: _____

Patient Lives With:

Self	☐	Child	☐
Spouse	☐	Parent(s)	☐
Sibling(s)	☐	Friend	☐
		Other	☐ _____

City of Residence: _____

Have you completed an advance directive? Yes ☐ No ☐

Have you completed a living will? Yes ☐ No ☐

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 ☐

Nutritional Supplements: _____

ALLERGIES TO MEDICATIONS: Yes ☐
No ☐

NAME OF DRUG(S)/TYPE OF REACTION:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS:

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

Vaccinations: *Please provide date of last vaccination*

Pneumonia: _____ **Flu:** _____ **COVID:** _____ **Shingles:** _____

FAMILY HISTORY:

Relative	Age, If Living	Health Problems	If Deceased, 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*

	BLOOD IN URINE	☐	# OF PREGNANCIES _____		
	BURNING WITH URINATION	☐	# OF MISCARRIAGES _____	SPOTTING	☐
	FREQUENT URINATION	☐	# OF ABORTIONS _____	CRAMPING	☐

URINARY/GYN	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	☐
	NERVOUSNESS	☐				

PATIENT'S SIGNATURE: _____

PHYSICIAN'S SIGNATURE: _____