PATIENT HEALTH HISTORY

Patient Name: ______________________________________ Date of birth: _______

**Surgical History:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Gender Identity:** Identify as male __ Identify as female __ Transgender __ Choose not to disclose __

Sex assigned at birth: Male __ Female __ Choose not to disclose __

Sexual orientation: Straight or heterosexual __ Bisexual __ Lesbian, Gay or Homosexual __
Something else __ Don't know __ Choose not to disclose __

**Menstrual history:** First date of last period _____________ if menopausal, age of last period ________
Periods irregular? Yes __ No __ Pregnancies ___ Living children ___ Miscarriages ___ Abortions ___

**Medical History:** Please circle all past or present medical problems and or symptoms

Anemia
Arthritis
Asthma
ADHD
Allergies
Aneurysm
Anxiety Disorder
Atherosclerosis
Heartburn/Reflux
Hiatal Hernia
Hyperthyroid
Disease
Nerve Disease
Parkinson's
Disease
Rheumatic Fever
Sleep Disorder
Tuberculosis
Varicosities

A-fib/Cardiac
Arrhythmia/Murmur
Back/neck problems
Blood Clots
Bowel Problems
Breast Problems
Congestive Heart Failure
Coronary Artery Disease
Dementia
Hemorrhoids
High Cholesterol
Hypothyroid Disease
Musculoskeletal Problems
Peripheral Vascular Disease
Radiation/Chemotherapy
Spinal Stenosis
Ulcers
Hospitalized/ER in the last year

Heart Disease
Chest Pain
High Blood Pressure
Diabetes
Depression
Dialysis
Ear
Problems/Hearing
Gout
Hepatitis/Liver
Disease
HIV/AIDS
Kidney Disease
Obesity
Pneumonia
Seizures
Stroke
Use of Blood
Thinners

Bleeding disorder
Easy Bruising
Cancer, type
Prostate Disease
Erectile Dysfunction
Eye Problems
Gastrointestinal Problems
Headaches/Migraines
Herpes
Hypertension
Lung Disease
Osteoporosis
Pulmonary
Disease/Embolism
Skin Problems
Tremors
Urinary/Bladder Problems
Vascular Disease

**Social History:**
Occupation:_________________

Education: Less then 8th grade__ High School__ 2 yrs. College__ 4 yrs. College__ Post Graduate__

Smoking Status: Never__ Former__ Current every day__ Current someday__ Unknown __

Ever used E-cigarettes or vape Yes __ No __

Smoking (How much?): 1PPW__ 2PPW__ 1/4 PPD__ 1/2PPD__ 1PPD__ 2PPD__ 3+ PPD __

Smoked since what age?:________ Tobacco-years of use?:__________

Chewing tobacco: none __1/days __2-4/day __5+day __

Illicit drugs:_______ History of drug/alcohol addiction?: Yes__ No _

Alcohol intake: None __Occasional __Moderate __Heavy __ Caffeine intake: None-__Occasional__
Moderate__ Heavy__

Caffeine intake: None __ Occasional __ Moderate __ Heavy _

Exercise Level: None__ Occasional__ Moderate__ Heavy__

Live alone or with others?: Alone__ With others__

Marital Status: Married__ Single__ Divorced__ Separated__ Widowed__ Domestic Partner__

Advanced directive: Yes __No __ What is your Code Status: Full Code __ DNR __ Other __ Undecided __

Do you have smoke and carbon monoxide detectors in your home? Yes__ No__

Are there guns in your home? Yes__ No__

**MEDICATION ALLERGIES:**
_____None______Aspirin _______Penicillin ______Sulfa Other:_____________

**MEDICATIONS:**

| Medication | Does(eg, mg/pill) | How many times per day | Prescribed by whom: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**FAMILY HISTORY:** Please indicate any family history of the following:

| Diagnosis | Family member(s) | Age at onset | Living? | Diagnosis | Family member(s) | Age at onset | Living? |
|---|---|---|---|---|---|---|---|
| ADD/ADHD | _______ | _____ | _____ | Eczema | _______ | _____ | _____ |
| Alcoholism | _______ | _____ | _____ | Hearing deficiency | _______ | _____ | _____ |
| Allergies | _______ | _____ | _____ | Elevated cholesterol | _______ | _____ | _____ |
| Alzheimer's diseases | _______ | _____ | _____ | High blood pressure | _______ | _____ | _____ |
| Asthma | _______ | _____ | _____ | Irritable bowel disease | _______ | _____ | _____ |
| Blood disease | _______ | _____ | _____ | Learning disability | _______ | _____ | _____ |
| Heart disease | _______ | _____ | _____ | Mental illness | _______ | _____ | _____ |
| Cancer, type: | _______ | _____ | _____ | Migraines | _______ | _____ | _____ |
| Stroke | _______ | _____ | _____ | Obesity | _______ | _____ | _____ |
| Depression | _______ | _____ | _____ | Osteoarthritis | _______ | _____ | _____ |
| Developmental delay | _______ | _____ | _____ | Osteoporosis | _______ | _____ | _____ |
| Diabetes | _______ | _____ | _____ | | | | |

**Patient Care Team:** Please list any specialist that you are seeing________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

**Health Screenings/Immunizations**:  Please specify if you have had any of the following.

Pap Smear ____________________________
Mammogram ____________________________
Chest x-ray ____________________________
Physical Exam ____________________________
Prostate Exam/PSA ____________________________
Stool Hemoccult ____________________________
Sigmoidoscopy ____________________________
Colonoscopy ____________________________
Cholesterol ____________________________
Blood Sugar ____________________________
BMI ____________________________
PPD ____________________________
Influenza Vaccine ____________________________
Tetanus/Td/Tdap Vaccine ____________________________
Hepatitis B/A Vaccine ____________________________
Chicken Pox/Vaccine ____________________________
Covid Vaccine ____________________________

**This has been reviewed by Doctor (Drs. Initials) ________          Updated (yearly) ________