

## PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Sex: Male  Female  Height \_\_\_\_\_ Weight \_\_\_\_\_

Pharmacy Preference (include location) \_\_\_\_\_

Name of referring physician \_\_\_\_\_ Name of Primary care physician \_\_\_\_\_

Other doctors you see (e.g. cardiologist or urologist): \_\_\_\_\_

REASON FOR VISIT TODAY \_\_\_\_\_

DATE OF INJURY OR DURATION OF PROBLEM \_\_\_\_\_

TESTS (e.g. X-RAYS, MRI's) YOU HAVE HAD FOR THIS PROBLEM: \_\_\_\_\_

PAST TREATMENTS YOU HAVE HAD FOR THIS PROBLEM: \_\_\_\_\_

**(TAB 1) MEDICATIONS: please list all medications currently being used**

Name of drug	Dosage	How often taken	Reason for taking

**(TAB 2) ALLERGIES: Are you allergic to ANY medication? No  Yes  If yes, please list below.  
Please include any intolerance to medications such as nausea.**

Name of Medication	Type of Reaction

**(TAB 3) NON MEDICATION ALLERGIES**

Are you allergic to: latex gloves? No  Yes  tape? No  Yes  contrast dye? No  Yes   
Are you allergic or intolerant to any foods? If yes, please describe \_\_\_\_\_

**(TAB 4) PAST HEALTH HISTORY:** Have you ever been **DIAGNOSED** with any major health problems? Indicate below:

**HEAD and FACE:**

Migraine headache Yes  No

**EYES:**

Glaucoma Yes  No

Cataracts Yes  No

**EARS:**

Do you wear a hearing aid? Yes  No

Balance disorder Yes  No

**MOUTH and THROAT:**

Sleep Apnea Yes  No

**HEART and BLOOD VESSELS:**

Elevated Cholesterol Yes  No

Hypertension Yes  No

Heart Attack Yes  No

Blood clots (thrombophlebitis) Yes  No

Peripheral Vascular disease Yes  No

**LUNGS and RESPIRATORY:**

Asthma Yes  No

Chronic Bronchitis Yes  No

Emphysema Yes  No

Lung Cancer Yes  No

**STOMACH and DIGESTIVE:**

Stomach ulcer Yes  No

Gastric reflux (GERD) Yes  No

Colon cancer Yes  No

Diverticulosis Yes  No

**KIDNEY and/or GENDER SPECIFIC:**

Prostate cancer Yes  No

Kidney stones Yes  No

Prostate enlargement Yes  No

Renal failure Yes  No

Kidney cancer Yes  No

**DIAGNOSES NOT LISTED** \_\_\_\_\_

**(TAB 5) SURGERIES AND HOSPITALIZATIONS**

Have you ever had any problems with anesthesia (being numbed or put to sleep)? Yes  No

If yes, please list what sort of problems. \_\_\_\_\_

Have you been hospitalized for a medical problem before? Yes  No

If yes, list hospitalizations, the reason for admission and the date. \_\_\_\_\_

Have you ever had surgery? Yes  No

List surgeries: \_\_\_\_\_

**BONES, JOINTS and MUSCLES:**

Rheumatoid Arthritis Yes  No

Other auto-immune disorder Yes  No

(if yes, name: \_\_\_\_\_)

Other previous spine or extremity problem: \_\_\_\_\_

**SKIN and/or BREASTS:**

Breast cancer Yes  No

Psoriasis Yes  No

**BRAIN and NERVOUS SYSTEM:**

Epilepsy (seizures) Yes  No

Multiple Sclerosis Yes  No

Stroke Yes  No

**MENTAL and EMOTIONAL HEALTH:**

Anxiety or Depression Yes  No

**GLANDS, HORMONES & SUGAR CONTROL:**

Diabetes Yes  No

Year diabetes began: \_\_\_\_\_

Thyroid excess Yes  No

Thyroid deficiency Yes  No

Thyroid cancer Yes  No

**BLOOD and LYMPH NODE:**

Anemia Yes  No

Type, if known: \_\_\_\_\_

**INFECTIOUS PROBLEMS:**

Hepatitis (A,B,orC? \_\_\_\_ ) Yes  No

AIDS or HIV Yes  No

**(TAB 6) SERIOUS INJURIES**

Have you ever had a serious injury such as a broken bone, or head, neck, back, or other injury? Yes  No   
 If yes, list them--include when they occurred. \_\_\_\_\_

**(TAB 8) FAMILY HISTORY**

List family members who have had the following health problems:

Specific Anesthesia Problem: Mother Father Brother Sister

Brain and Nervous: Stroke Mother Father Brother Sister

Heart and Blood Vessels:

Heart Attack Mother Father Brother Sister

High Blood Pressure Mother Father Brother Sister

Cancer (list types) \_\_\_\_\_ Mother Father Brother Sister

\_\_\_\_\_ Mother Father Brother Sister

Bleeding/clotting problems Mother Father Brother Sister

**OTHER PERTINENT FAMILY HISTORY:**

**(TAB 9) SOCIAL HISTORY**

What is or was your occupation? (enter "disabled" if applicable and give reason) \_\_\_\_\_

Check here if you are retired.  Marital Status \_\_\_\_\_

Have you ever used tobacco in any form?.....  No  Yes

If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Have you ever used alcohol in any form? .....  No  Yes

If yes, please complete the following:

Type of Alcohol	From year	To year
Beers per week: _____		
Wine glasses per week: _____		
Other: (list type) _____		

Are you **RIGHT HANDED** \_\_\_\_\_, **LEFT HANDED** \_\_\_\_\_, or **AMBIDEXTEROUS** \_\_\_\_\_ ?

Caffeine use:  None  About 1 drink/day  2-3 drinks/day  4 or more drinks/day  other \_\_\_\_\_

Personal handicaps such as need for wheelchair, cane, walker, or oxygen \_\_\_\_\_

Home setting (who lives at home with you?): \_\_\_\_\_

(Other): List regular activities other than work that are important to you \_\_\_\_\_

**(TAB 10) REVIEW OF SYSTEMS: (Conditions you have or have had RECENTLY)****General health problems:**

fever,  sleeping problems,  unintentional weight loss  
 details: \_\_\_\_\_

**Ear Problems:**  hearing loss,  dizziness

details: \_\_\_\_\_

**Nose and Throat:**  deviated septum  frequent snoring

details: \_\_\_\_\_

**Heart or Circulation:**  chest pain,

irregular heartbeat,  swelling ankles

details: \_\_\_\_\_

**Lung or Respiratory:**  shortness of breath

have to use oxygen

**Stomach or Digestive problems:**  constipation

abdominal pain,  diarrhea,  heartburn,

details: \_\_\_\_\_

**Kidney/Bladder problems:**  recent urinary tract infection

incontinence

details: \_\_\_\_\_

**Bones Joints and Muscles:**  pain in back,  stiffness

swelling of joints  use of cane or walker \_\_\_\_\_

details: \_\_\_\_\_

**Skin:**  rash

details: \_\_\_\_\_

**Brain or Nervous System:**  seizures,  headaches

details: \_\_\_\_\_

**Problems with Blood:**

bleed easily after injury,  bruise easily

details: \_\_\_\_\_

**Immune System:**  don't heal well

get infections easily

details: \_\_\_\_\_

**Are you pregnant?**  Yes  No  Maybe

**PROBLEM NOT LISTED:** \_\_\_\_\_

---

*Thank you!*