**MEDICAL AND HEALTH HISTORY**

Your personal health history is a vital part in visit with us today, please complete the following information.

|  |  |  |
| --- | --- | --- |
| **MAIN PROBLEM** | | |
| What is the reason for your visit today? |  | |
| What happened RECENTLY to make you decide to seek help now? | |  |
|  | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date of last physical exam: | | |  | | Name of Provider: |  |
|  | | | | | | |
| Medical Conditions diagnosed by a doctor: | | | |  | | |
|  | | | | | | |
| Surgeries: |  | | | | | |
|  | | | | | | |
| Other hospitalizations: | |  | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SYMPTOMS -** *Please mark if you have now* | | | | | | | | | | | | |
| Fever | | Yes |  | No |  | Difficulty starting/stopping stream | | Yes |  | No |  | |
| Unexplained weight loss | | Yes |  | No |  | Joint pain | | Yes |  | No |  | |
| Chills | | Yes |  | No |  | Black stools | | Yes |  | No |  | |
| Changes in vision | | Yes |  | No |  | Foot swelling | | Yes |  | No |  | |
| Difficulty swallowing | | Yes |  | No |  | Depression | | Yes |  | No |  | |
| Problems with hearing | | Yes |  | No |  | Anxiety | | Yes |  | No |  | |
| Chest pain | | Yes |  | No |  | Panic attacks | | Yes |  | No |  | |
| Racing heart | | Yes |  | No |  | Excessive thirst | | Yes |  | No |  | |
| Palpitations | | Yes |  | No |  | Frequent urination | | Yes |  | No |  | |
| Cough | | Yes |  | No |  | Swelling in the neck | | Yes |  | No |  | |
| Wheezing | | Yes |  | No |  | Swollen glands | | Yes |  | No |  | |
| Shortness of breath | | Yes |  | No |  | Easy bleeding | | Yes |  | No |  | |
| Stomach pains | | Yes |  | No |  | Poor healing | | Yes |  | No |  | |
| Blood in stool | | Yes |  | No |  | Frequent headaches | | Yes |  | No |  | |
| Constipation | | Yes |  | No |  | Loss of consciousness | | Yes |  | No |  | |
| Blood in urine | | Yes |  | No |  | Numbness in arms/legs | | Yes |  | No |  | |
| Burning during urination | | Yes |  | No |  | Worrisome or changing skin lesions | | Yes |  | No |  | |
| Skin rashes | | Yes |  | No |  | Hair loss | | Yes |  | No |  | |
| **CURRENT MEDICATIONS** | *(Include - all Prescriptions and over the counter including Vitamins)* | | | | | | | | | | | |
| **Name of Medication** | **Dose** | | | | | | **Frequency** | | | | |  |
|  |  | | | | | |  | | | | |  |
|  |  | | | | | |  | | | | |  |
|  |  | | | | | |  | | | | |  |
|  |  | | | | | |  | | | | |  |
|  |  | | | | | |  | | | | |  |
|  |  | | | | | |  | | | | |  |
| **Allergies to medications** | **Reaction** | | | | | |  | | | | |  |
|  |  | | | | | |  | | | | |  |
|  |  | | | | | |  | | | | |  |
|  |  | | | | | |  | | | | |  |

*Please use the back side of this paper if more room is needed.* ***Continued on back YES\_\_\_ No \_\_\_***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSONAL HISTORY - Do you have any history of the following conditions?** | | | | | | | | | **If YES to any please Explain** | | | | | | |  | | | |
| Thyroid Problems | | | | Yes | |  | No |  | |  | | | | | | | |
| Seizures | | | | Yes | |  | No |  | |  | | | | | | | |
| Stroke | | | | Yes | |  | No |  | |  | | | | | | | |
| Asthma | | | | Yes | |  | No |  | |  | | | | | | | |
| C.O.P.D. | | | | Yes | |  | No |  | |  | | | | | | | |
| Sleep Apnea | | | | Yes | |  | No |  | |  | | | | | | | |
| Coronary Artery Disease | | | | Yes | |  | No |  | |  | | | | | | | |
| Congestive Heart Failure | | | | Yes | |  | No |  | |  | | | | | | | |
| Chest Pain | | | | Yes | |  | No |  | |  | | | | | | | |
| High Blood Pressure | | | | Yes | |  | No |  | |  | | | | | | | |
| Elevated Cholesterol | | | | Yes | |  | No |  | |  | | | | | | | |
| Heart Attack | | | | Yes | |  | No |  | |  | | | | | | | |
| Implantable Devices | | | | Yes | |  | No |  | |  | | | | | | | |
| Cardiac Arrhythmia | | | | Yes | |  | No |  | |  | | | | | | | |
| Rheumatic Fever | | | | Yes | |  | No |  | |  | | | | | | | |
| Diabetes | | | | Yes | |  | No |  | |  | | | | | | | |
| Liver Problems | | | | Yes | |  | No |  | |  | | | | | | | |
| Stomach Problems | | | | Yes | |  | No |  | |  | | | | | | | |
| Irritable Bowel | | | | Yes | |  | No |  | |  | | | | | | | |
| Syndrome | | | | Yes | |  | No |  | |  | | | | | | | |
| Reflux (G.E.R.D.) | | | | Yes | |  | No |  | |  | | | | | | | |
| Kidney Problems | | | | Yes | |  | No |  | |  | | | | | | | |
| Incontinence of Urine | | | | Yes | |  | No |  | |  | | | | | | | |
| Genitourinary Problems | | | | Yes | |  | No |  | |  | | | | | | | |
| Osteoporosis | | | | Yes | |  | No |  | |  | | | | | | | |
| Back or Neck Problems | | | | Yes | |  | No |  | |  | | | | | | | |
| Arthritis | | | | Yes | |  | No |  | |  | | | | | | | |
| Skin Problems | | | | Yes | |  | No |  | |  | | | | | | | |
| Anemia | | | | Yes | |  | No |  | |  | | | | | | | |
| Blood Disorder | | | | Yes | |  | No |  | |  | | | | | | | |
| M.R.S.A. / V.R.E. | | | | Yes | |  | No |  | |  | | | | | | | |
| Tuberculosis | | | | Yes | |  | No |  | |  | | | | | | | |
| difficile | | | | Yes | |  | No |  | |  | | | | | | | |
| Hepatitis | | | | Yes | |  | No |  | |  | | | | | | | |
| HIV or AIDS | | | | Yes | |  | No |  | |  | | | | | | | |
| Depression | | | | Yes | |  | No |  | |  | | | | | | | |
| Anxiety | | | | Yes | |  | No |  | |  | | | | | | | |
| Eating Disorder | | | | Yes | |  | No |  | |  | | | | | | | |
| Menstrual Problems | | | | Yes | |  | No |  | |  | | | | | | | |
| Abnormal Pap Smear | | | | Yes | |  | No |  | |  | | | | | | | |
| Cancer | | | | Yes | |  | No |  | |  | | | | | | | |
| Drug or Alcohol Addiction | | | | Yes | |  | No |  | |  | | | | | | | |
| Other Medical Problems | | | | Yes | |  | No |  | |  | | | | | | | |
| **SOCIAL HISTORY** | | | |  | |  |  | |  | | | |  | | | | |
| Do you feel safe at home | | | | Yes | |  | No |  | |  | | | | | | | |
| Do you want to discuss abuse | | | | Yes | |  | No |  | |  | | | | | | | |
| Is someone threatening you | | | | Yes | |  | No |  | |  | | | | | | | |
| Do you smoke? | | | | Yes | |  | No |  | | If Yes, how many per day? | | | | | | | |
| Do you drink? | | | | Yes | |  | No |  | | If Yes, how much? | | | | | | | |
| Do you exercise regularly? | | | | Yes | |  | No |  | | If Yes how often? | | | | | | | |
| Are you pregnant? | | | | Yes | |  | No |  | | **Are you Employed?** Yes No  If So Where? | | | | | | | |  | |
| Is your Mother Deceased? | | | | Yes | |  | No |  | | **Marital Status**  Married Single Divorced Other | | | | | | | |  | |
| Is your Father Deceased? | | | | Yes | |  | No |  | | **Highest Level of Education**  College High School GED Other | | | | | | | |  | |
| **FAMILY HISTORY** *(If yes to any, please list relationship)* | | | | | | | | | | | If Unknown Please check here | | | |  | |  | |
|  |  | **Relationship** |  | |  | | | | | | |  | | **Relationship** |  | | |
| Aneurysms | Yes |  | No | | Diabetes | | | | | | | Yes | |  | No | | |
| Bleeding tendencies | Yes |  | No | | Alcohol dependence | | | | | | | Yes | |  | No | | |
| Breast cancer | Yes |  | No | | Drug abuse | | | | | | | Yes | |  | No | | |
| Colo-Rectal cancer | Yes |  | No | | Heart problems | | | | | | | Yes | |  | No | | |
| Ovarian cancer | Yes |  | No | | Hypertension | | | | | | | Yes | |  | No | | |
| Pancreatic cancer | Yes |  | No | | Stroke | | | | | | | Yes | |  | No | | |
| Other cancers | Yes |  | No | | Mental illness | | | | | | | Yes | |  | No | | |

Please list any other questions or concerns you have:

|  |
| --- |
|  |

I have answered the above questions to the best of my knowledge

|  |  |  |
| --- | --- | --- |
|  |  |  |
| *Patient / Legal Guardian Signature* |  | *Date* |

**Medical and Health History Form Instructions**

The Medical History and Health History are very important documents for the initial patient visit. Most patients dislike filling out forms when they arrive and sometimes they do not bring all the necessary information with them. By completing this form before they arrive, not only do they save both the practice and themselves some time, the doctor also has the necessary information to meet documentation requirements for Review of Systems and Health History.

The information on this form helps the provider correctly assess the patient’s condition and appropriately review concurrent conditions which may contribute to their reason for the encounter.