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. Use additional sheets and attach to this if needed. (Date filled out: _______________)

Patient Name: ____________________________ Age______ Appointment Date _____________ ☐ Male ☐ Female

Name of Primary Care Physician (PCP) __________________________________ PCP phone #: ________________

Pharmacy Name (include location) __________________________________ Pharmacy phone #: ________________

Are you taking ANY kind of medication now? ☐ **No** ☐ **Yes** If yes please list below.

MEDICATION NAME	DOSE PER PILL (MG) TIMES PER DAY

Are you **allergic** to any medications? ☐ **No** ☐ **Yes** If yes please list below.

MEDICATION NAME	TYPE OF REACTION

NON-MEDICATION ALLERGIES

Are you allergic to any food? Specify________________________ Type of reaction____________________________
Are you allergic to any non-medical things such as latex, tape, metal? ☐ No ☐ Yes
If yes, specify______________________________ Type of reaction____
Are you allergic to x-ray dye or contrast? ☐ No ☐ Yes Iodine/Betadine? ☐ No ☐ Yes

Past Medical History- Problems you have been *diagnosed with*: If yes please specify type.

Anemia	☐ No ☐ Yes	Fibromyalgia	☐ No ☐ Yes	Osteoporosis	☐ No ☐ Yes
Angina	☐ No ☐ Yes	Gastrointestinal Reflux	☐ No ☐ Yes	Pacemaker	☐ No ☐ Yes
Anxiety	☐ No ☐ Yes	Heart Attack (MI)	☐ No ☐ Yes	Peripheral Vascular Ds.	☐ No ☐ Yes
Arthritis	☐ No ☐ Yes	Heart Problems	☐ No ☐ Yes	Pulmonary Embolism	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	Hemophilia	☐ No ☐ Yes	Rheumatoid Arthritis	☐ No ☐ Yes
Atrial Fibrillation	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes	Scoliosis	☐ No ☐ Yes
Bleeding Disorder	☐ No ☐ Yes	HIV or Aids	☐ No ☐ Yes	Seizures/Epilepsy	☐ No ☐ Yes
Cancer (Type)	☐ No ☐ Yes	Hypertension	☐ No ☐ Yes	Shingles	☐ No ☐ Yes
Congestive Heart Failure	☐ No ☐ Yes	Hyperthyroidism	☐ No ☐ Yes	Spinal Stenosis	☐ No ☐ Yes
COPD	☐ No ☐ Yes	Hypothyroidism	☐ No ☐ Yes	Stroke	☐ No ☐ Yes
Coronary Artery Disease	☐ No ☐ Yes	Kidney Disease	☐ No ☐ Yes		
Depression	☐ No ☐ Yes	Liver Disease	☐ No ☐ Yes		
Diabetes (Type)	☐ No ☐ Yes	Lung Disease	☐ No ☐ Yes		
Disk Disorder Back	☐ No ☐ Yes	Migraine Headaches	☐ No ☐ Yes		
Disk Disorder Neck	☐ No ☐ Yes	Neuritis	☐ No ☐ Yes		

SURGERIES AND HOSPITALIZATIONS

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

If yes please list what type of problems____

Have you ever had surgery before? ☐ No ☐ Yes

If yes please list all surgeries, the dates they occurred, where they happened, and the name of the surgeon:

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____

____

FAMILY HISTORY

Alcoholism	☐ Father ☐ Mother ☐ Brother ☐ Sister	Epilepsy/Seizures	☐ Father ☐ Mother ☐ Brother ☐ Sister
Anemia	☐ Father ☐ Mother ☐ Brother ☐ Sister	Heart Problems	☐ Father ☐ Mother ☐ Brother ☐ Sister
Arthritis	☐ Father ☐ Mother ☐ Brother ☐ Sister	Hypertension	☐ Father ☐ Mother ☐ Brother ☐ Sister
Bleeding Disorder	☐ Father ☐ Mother ☐ Brother ☐ Sister	Lung Disease	☐ Father ☐ Mother ☐ Brother ☐ Sister
Cancer	☐ Father ☐ Mother ☐ Brother ☐ Sister	Orthopedic Problems	☐ Father ☐ Mother ☐ Brother ☐ Sister
Dementia	☐ Father ☐ Mother ☐ Brother ☐ Sister	Osteoporosis	☐ Father ☐ Mother ☐ Brother ☐ Sister
Depression	☐ Father ☐ Mother ☐ Brother ☐ Sister	Stroke	☐ Father ☐ Mother ☐ Brother ☐ Sister
Diabetes	☐ Father ☐ Mother ☐ Brother ☐ Sister		☐ Father ☐ Mother ☐ Brother ☐ Sister

SOCIAL HISTORY

Current Tobacco Use	☐ None ☐ Packs per day ___ ____ Years smoked: ____ ☐ Other types of tobacco
Former Tobacco Use:	☐ None ☐ Packs per day ___ ____ Years smoked: ____ When did you quit? ____
Alcohol Use:	☐ None ☐ Social ☐ Other Frequency:______________________________
Drug Use:	☐ None ☐ Type/Frequency___________________________________
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Home Setting:	☐ Lives Alone ☐ Lives with Spouse ☐ Lives with Children ☐ Nursing Home ☐ Other
Exercise Level:	☐ None ☐ Light/Occasional ☐ Moderate/Weekly ☐ Heavy/Daily
Sporting Activities:	
Occupation:	Prior or Current:__________________________ ☐ retired / on disability (circle)

REVIEW OF SYSTEMS

List any problems you have or have had recently in the following areas. **Circle** the symptom you are having.

General Constitutional (change in appetite, fatigue, fever, sleeping problems, unintentional weight gain, unintentional weight loss) or ☐ **None**

Head & Face (frequent headache, frequent face pain, other__________________) or ☐ **None**

Neck (neck masses, pain in neck, stiffness in neck) or ☐ **None**

Heart and Blood Vessels (chest pain, leg cramps, swelling of legs/ankles) or ☐ **None**

Lungs & respiratory system (pain or tightness in chest, difficulty breathing/ shortness of breath,) or ☐ **None**

Stomach & digestive system (abdominal pain or tenderness, constipation, heartburn, painful swallowing, rectal pain) or ☐ **None**

Bones, Joints, or Muscles (cramping, pain in back, painful joints, sore muscles stiffness, weakness) or ☐ **None**

Skin (bruise easily, painful skin) or ☐ **None**

Brain and nervous system (loss of consciousness, numbness, seizures, tingling, weakness) or ☐ **None**

Mental and Emotional Health (DWI arrest, trouble sleeping, anxiety, depression, suicidal thoughts) or ☐ **None**

Blood & Lymph Nodes (bruise easily, bone pain) or ☐ **None**

OTHER PROBLEMS NOT LISTED____