

Patient Health History

Name: _____

Patient Label

Health History Review: (circle all that applies and complete blank lines as necessary)

CARDIOVASCULAR:	PULMONARY:	Hepatitis (Type A B C)
High blood pressure	Short of breath at rest/with activity	Cirrhosis
History of heart attack	Asthma	Chronic pancreatitis
Irregular heart beats	Emphysema	Gall stones
Heart murmur	Chronic bronchitis	Gall bladder disease/surgery
Chest pain: At rest/Activity	Difficulty sleeping flat	
History of angioplasty	Snoring	GENITOURINARY:
History of heart surgery	Awakening at night	Frequent urination
Pacemaker	Morning headaches	# of night time bathroom trips: _____
CHF	Daytime drowsiness	Leak urine with:
High cholesterol	Observed apnea episodes	laughter/sneezing/coughing
High triglycerides	Chronic insomnia	Frequent bladder infections
Blood clot in leg (DVT)	Sleep apnea	Interstitial cystitis
Blockages in legs	CPAP/BiPAP	Kidney disease
Blood transfusion		Men:
Year _____	GASTROINTESTINAL:	Erectile dysfunction
Known HIV exposure	Difficulty chewing	Last prostate exam _____
Rheumatic Fever	Difficulty swallowing	Enlarged breast tissue
Varicose veins	Frequent nausea/vomiting	
Pulmonary embolism	Heartburn/reflux	Women:
	Hiatal hernia	Method of birth control _____
ENDOCRINE:	Ulcers	Hysterectomy
Diabetes (type 1 or type 2)	Esophagitis	Ovaries removed
Prediabetes	Esophageal varices	Menopause
Gestational diabetes	Esophageal strictures	Last menstrual period _____
Hyperthyroid (high)	Chronic constipation	Irregular periods
Hypothyroid (low)	Chronic diarrhea	Heavy periods
Chronic steroid use	Irritable bowel syndrome	Polycystic ovarian disease
Cushings disease	Ulcerative colitis	Infertility
	Chron's disease	Facial hair growth
CONSTITUTIONAL:	Fatty liver	Breast cancer history
Fatigue/tiredness	Elevated liver enzymes	Last pap smear _____
Fever	Portal Hypertension	Last mammogram _____
Night sweats		Difficulty becoming pregnant

Patient Label

Health History Review: (circle all that applies and complete blank lines as necessary)

HEAD AND NECK:	SKIN:	MUSCULOSKELETAL:
Recent change in vision Ringing in ears Vertigo Loss of smell Hoarseness	Wounds that don't heal Skin cancer Abnormal moles Chronic rash Psoriasis/Eczema Lupus Scleroderma Boils Skin infections	Painful joints: shoulders/hips/knees/ankles ___limits ability to walk ___limits ability to exercise Chronic low back pain Herniated disc Where? _____ Numbness of legs/feet Joint replacement (hip/knee) Hernia Type or location: _____ Year repaired: _____
NUEROLOGICAL:	PYSCHOLOGICAL:	
Seizures Muscle weakness Tremors Narcolepsy Stroke Migraines - frequency _____ Fibromyalgia Muscular Dystrophy Multiple Sclerosis	Depression Anxiety disorder Suicidal thoughts Suicidal attempts Bi-polar disorder Schizophrenia Anorexia Bulimia	Swelling of legs/feet Rheumatoid Arthritis Osteoarthritis Osteoporosis

Past Surgical History: (Please list all surgical procedures and operations)

Procedure	Date

Please indicate if there is a family history of: (Circle all that apply)

- | | | |
|---------------|---------------------|---------------------------------|
| Obesity | Heart Disease | Bleeding Disorders |
| Diabetes | High Blood Pressure | Pulmonary Embolus |
| Breast Cancer | Colon Cancer | Lung disease, asthma, emphysema |

Please list any allergies to medicine, food, or environmental triggers:

Patient Label

Medications: *(please list all medications and supplements you are currently taking)*

Name of Medication	Dosage	Frequency	Reason for taking this medicine

Social History:

Do you use tobacco? Yes No Years smoking: _____ Years since quit? _____
 Do you use alcohol? Yes No Amount and frequency: _____
 Do you or have you used intravenous drugs? Yes No
 Do you use recreational drugs? Yes No
 If yes, name of substance and date of last usage: _____
 Do you have a history of drug addiction? Yes No

Medical Testing:

When was your last chest x-ray? _____
 When was your last EKG? _____
 When was your last cardiac stress test? _____
 Have you had blood work in the last 12 months? _____

Please sign:

(By signing below you are acknowledging that the information you have provided above is correct to the best of your ability and knowledge.)

Patient Signature: _____ **Date:** _____