Patient Health History

Name:_____

Patient Label

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

CARDIOVASCULAR:
- High blood pressure
- History of heart attack
- Irregular heart beats
- Heart murmur
- Chest pain: At rest/Activity
- History of angioplasty
- History of heart surgery
- Pacemaker
- CHF
- High cholesterol
- High triglycerides
- Blood clot in leg (DVT)
- Blockages in legs
- Blood transfusion
  Year_____
- Known HIV exposure
- Rheumatic Fever
- Varicose veins
- Pulmonary embolism

ENDOCRINE:
- Diabetes (type 1 or type 2)
- Prediabetes
- Gestational diabetes
- Hyperthyroid (high)
- Hypothyroid (low)
- Chronic steroid use
- Cushings disease

CONSTITUTIONAL:
- Fatigue/tiredness
- Fever
- Night sweats

PULMONARY:
- Short of breath
  at rest/with activity
- Asthma
- Emphysema
- Chronic bronchitis
- Difficulty sleeping flat
- Snoring
- Awakening at night
- Morning headaches
- Daytime drowsiness
- Observed apnea episodes
- Chronic insomnia
- Sleep apnea
  CPAP/BiPAP

GASTROINTESTINAL:
- Difficulty chewing
- Difficulty swallowing
- Frequent nausea/vomiting
- Heartburn/reflux
- Hiatal hernia
- Ulcers
- Esophagitis
- Esophageal varices
- Esophageal strictures
- Chronic constipation
- Chronic diarrhea
- Irritable bowel syndrome
- Ulcerative colitis
- Chron's disease
- Fatty liver
- Elevated liver enzymes
- Portal Hypertension
- Hepatitis (Type A B C)
- Cirrhosis
- Chronic pancreatitis
- Gall stones
- Gall bladder disease/surgery

GENITOURINARY:
- Frequent urination
- # of night time bathroom trips:___
- Leak urine with:
  laughter/sneezing/coughing
- Frequent bladder infections
- Interstitial cystitis
- Kidney disease

Men:
- Erectile dysfunction
- Last prostate exam_____
- Enlarged breast tissue

Women:
- Method of birth control_____
- Hysterectomy
- Ovaries removed
- Menopause
- Last menstrual period_____
- Irregular periods
- Heavy periods
- Polycystic ovarian disease
- Infertility
- Facial hair growth
- Breast cancer history
- Last pap smear_____
- Last mammogram_____
- Difficulty becoming pregnant

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

Patient Label

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

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:**_____