HEALTH HISTORY FORM

PLEASE COMPLETE ALL FIELDS & SIGN ON SECOND PAGE.

Patient Name:
Patient #:
Date of Birth:
Primary Care Physician:

Date:

PATIENT MEDICAL HISTORY. Check all that apply.

- ☐ None
- ☐ AIDS/HIV
- ☐ Acid reflux/GERD
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer ____________
- ☐ Cataracts
- ☐ Congestive heart failure
- ☐ Concussion
- ☐ Chronic obstructive pulmonary disease
- ☐ Dementia/Alzheimer's
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Emphysema
- ☐ Fracture ____________
- ☐ Gout
- ☐ Heart attack
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Kidney disease/stones
- ☐ Lupus (erythematosis)
- ☐ Mitral valve prolapse
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteoporosis/osteopenia
- ☐ Parkinson's disease
- ☐ Peptic ulcer disease
- ☐ Peripheral vascular disease
- ☐ Polio
- ☐ Psoriasis
- ☐ Renal failure/Dialysis
- ☐ Rheumatoid arthritis
- ☐ Schizophrenia
- ☐ Seizure disorder
- ☐ Sickle cell disease
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Valvular heart disease
- ☐ ____________
- ☐ ____________
- ☐ ____________

PAST SURGICAL HISTORY. Check all that apply.

- ☐ None
- ☐ Appendectomy
- ☐ Arthroscopy ____________
- ☐ Back Surgery ____________
- ☐ Bowel resection
- ☐ Breast ____________
- ☐ Bunionectomy
- ☐ Carpal tunnel release
- ☐ Cataract excision
- ☐ Caesarean section
- ☐ Coronary artery angioplasty
- ☐ Cholecystectomy
- ☐ Fracture repair
- ☐ Heart bypass
- ☐ Hernia repair
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Knee replacement
- ☐ Removal of both ovaries
- ☐ Sinus surgery
- ☐ Tonsillectomy/ Adenoidectomy
- ☐ ____________
- ☐ ____________

REVIEW OF SYSTEMS. Check all that apply.

Musculoskeletal

- ☐ Joint pain
- ☐ Joint stiffness/swelling
- ☐ Weakness of muscles/joints
- ☐ Muscle pain/cramps
- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty in walking

Constitutional Symptoms

- ☐ Bad general health lately
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

Neurological

- ☐ Numbness or tingling
- ☐ Tremors
- ☐ Paralysis
- ☐ Lightheaded/Dizzy

Hematologic

- ☐ Cuts slow to heal
- ☐ Tendency to bleed/bruise
- ☐ Anemia
- ☐ Enlarged glands

Integumentary (Skin)

- ☐ Rash or itching
- ☐ Changes in skin color
- ☐ Varicose veins

Allergies

- ☐ No known allergies
- ☐ Tape ____________
- ☐ Erythromycin
- ☐ Codeine
- ☐ Sulfa
- ☐ Metal
- ☐ Latex
- ☐ Penicillin
- ☐ Exam dye (iodine)
- ☐ Topical iodine
- ☐ ____________
- ☐ ____________

CURRENT MEDICATIONS

- ☐ None
- ☐ See attached list

Drug Name		

MARITAL STATUS

- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Divorced

OCCUPATIONAL HISTORY

- ☐ Retired
- ☐ Student
- ☐ Not presently employed
- ☐ Disabled
- ☐ Homemaker
- ☐ Employed
  Occupation:______________

ALCOHOL HISTORY

- ☐ Never
- ☐ Rarely (1-2 times per month)
- ☐ Moderately (1-2 times per week)
- ☐ Heavy

TOBACCO HISTORY

- ☐ Never smoked
- ☐ Not currently, quit _ yrs ago
- ☐ Chew tobacco
- ☐ Smoke______ packs per day

DRUG DEPENDENCY HISTORY (NARCOTIC DRUG USAGE)

- ☐ Never
- ☐ Not currently, _____ yrs ago
- ☐ Moderately
- ☐ Daily

FAMILY HISTORY

- ☐ Anemia
- ☐ Anesthesia problems
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ ____________________

__NONE OF THE ABOVE

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the medical staff to perform the necessary services I may need.

Patient Signature ______________________________ Date ______________

______________________________ ______________

______________________________ ______________

OFFICE USE ONLY
MA INIT:
DATE: