

Today's Date: _____

Health History

Patient Name _____ Birthdate _____ Age _____

Date of last physical exam _____ Former Primary Care Physician: _____

Pharmacy: _____ Durable Medical Equipment Co _____

Past Medical/Surgical history Have you had? (mark box ☒)	Review of Systems Do you have? (mark box ☒)	
<input type="checkbox"/> Heart Trouble <input type="checkbox"/> MI/Heart Attack <input type="checkbox"/> Angina/chest pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis, emphysema <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Liver problems <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Arthritis, joint or back pain <input type="checkbox"/> Stroke (What weakness do you have from the stroke?? _____ <input type="checkbox"/> Kidney problems <input type="checkbox"/> Alzheimer's, other brain disease <input type="checkbox"/> History of cancer Type: _____ Type: _____ <input type="checkbox"/> HIV positive or AIDS <input type="checkbox"/> Other: _____	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Weight loss <input type="checkbox"/> Fever, chills <input type="checkbox"/> Weakness, fatigue or tiredness <input type="checkbox"/> Blurred vision, eye discharge <input type="checkbox"/> Earache or ear discharge <input type="checkbox"/> Sore throat or oral lesions <input type="checkbox"/> Stuffy nose or post nasal drip <input type="checkbox"/> Cough/sputum production <input type="checkbox"/> Heartburn <input type="checkbox"/> Constipation or Diarrhea <input type="checkbox"/> Bloody/tarry stools <input type="checkbox"/> Stomach pain <input type="checkbox"/> Difficulty controlling urine <input type="checkbox"/> Blood in urine <input type="checkbox"/> Sexual problems <input type="checkbox"/> Joint pains <input type="checkbox"/> Back pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hair loss <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> CPAP	<input type="checkbox"/> Skin rash <input type="checkbox"/> Itching <input type="checkbox"/> Varicose veins <input type="checkbox"/> Swelling of legs <input type="checkbox"/> Breast lump or discharge <input type="checkbox"/> Anemia <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Recurrent infections <input type="checkbox"/> Headache <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Memory Loss <input type="checkbox"/> Frequent falls <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Snoring at night <input type="checkbox"/> Daytime sleepiness <input type="checkbox"/> Hearing problems: <input type="checkbox"/> Other problems: _____

List Previous Biopsies, Endoscopies and Surgeries (Type and Date)
1.
2.
3.
4.
5.
6.
7.

Date of Last:		
Pap:	Mammogram:	Bone Density:
PSA:	Colonoscopy:	Complete Bloodwork:

Occupation (if retired, occupation before retirement):	
Education Level:	Difficulty Reading? <input type="checkbox"/> Yes <input type="checkbox"/> No

Social History - Do you?			
<input type="checkbox"/> Smoke	# packs per day:	# years:	<input type="checkbox"/> Quit When did you quit?
<input type="checkbox"/> Drink alcohol	# drinks per day/week	<input type="checkbox"/> Recreational drug use	
<input type="checkbox"/> Victim of abuse/neglect			

Family History				
Relative	Age (if living)	Age/Year of Death	Current Illness	Cause of Death
Mother				
Father				
Brother(s)				
Sister(s)				
Children				

Current Medications		
Drug name	Dose	Time of day taken

Medication Allergies	Vaccines
Include Drug Name and Reaction	Flu: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
	Pneumonia: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
	Prevnar 13: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
	Shingles: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
	Tetanus: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other:

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