

# PATIENT HEALTH HISTORY

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Patient Height \_\_\_\_\_ Patient Weight \_\_\_\_\_

## Chief Complaint

Reason for today's visit? \_\_\_\_\_

Current problem is the result of a(n): Check all that apply

Car Accident  Work Accident  Accident  Other \_\_\_\_\_

Date of onset \_\_\_\_\_

## Past Medical History

Please list any medical conditions (i.e hypertension, diabetes, etc) or major injuries: \_\_\_\_\_

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Surgeries/Hospitalizations	Year	Complications

Have you ever had an antibiotic resistant infection?  Yes  No

If Yes, was it MRSA or VRF? (Please circle)

Have you ever had problems with anesthesia?  Yes  No

Do you take Aspirin?  Yes  No If Yes, how often :

Current Medications Including Over the Counter	Dose	Frequency

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
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ALLERGIES/TYPES OF REACTIONS
Please circle: <b>Latex</b> Yes No <b>Iodine</b> Yes No <b>Shellfish</b> Yes No <b>Asthma</b> Yes No

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

### SOCIAL HISTORY

Do you have children?  Yes     No    How many? \_\_\_\_\_

Do you live alone?  Yes     No    Who lives with you? \_\_\_\_\_

Do you smoke?  Yes, I've smoked \_\_\_\_\_ packs of cigarettes per day for \_\_\_\_\_ years.  
 Yes, I smoke cigars or a pipe.  
 No, I have never smoked.  
 No, I quit \_\_\_\_\_ years ago. At that time I was smoking \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

Do you drink alcohol?     No, never (or rarely)     No, but I used to  
 Yes     Daily     1 or more times a week     1 or more times a month

Are you at risk for AIDS (e.g., sexual orientation, drug abuse, previous blood transfusion)?  
 No             Yes, please explain \_\_\_\_\_  
 Deferred by patient: Signature \_\_\_\_\_

Patient Name \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### REVIEW OF SYSTEMS

Do you currently have any problems with:

Eyes Circle One  
 Blurred or double vision..... Yes No  
 Glaucoma..... Yes No  
 Any other..... Yes No

Ear, Nose, Mouth, & Throat Circle One  
 Hearing loss or ringing..... Yes No  
 Earaches or drainage..... Yes No  
 Any other..... Yes No

Gastrointestinal  
 Nausea or vomiting..... Yes No  
 Change in bowel movements..... Yes No  
 Any other..... Yes No

Genitourinary  
 Frequent urination..... Yes No  
 Burning or painful urination..... Yes No  
 Any other..... Yes No

Psychiatric  
 Memory loss or confusion..... Yes No  
 Depression..... Yes No  
 Any other..... Yes No

Endocrine  
 Diabetes..... Yes No  
 Glandular or hormone problem..... Yes No  
 Any other..... Yes No

Cardiovascular  
 Heart Trouble..... Yes No  
 Chest pain or angina pectoris..... Yes No  
 Hypertension..... Yes No  
 Any other..... Yes No

Respiratory  
 Shortness of breath..... Yes No  
 Spitting up of blood..... Yes No  
 Asthma or wheezing..... Yes No  
 Any other..... Yes No

Constitutional  
 Recent weight change..... Yes No  
 Fever..... Yes No  
 Headaches..... Yes No  
 Any other..... Yes No

Musculoskeletal  
 Joint pain..... Yes No  
 Weakness of muscles or joints..... Yes No  
 Neck or back pain..... Yes No  
 Any other..... Yes No

Neurological  
 Light headed or dizzy..... Yes No  
 Convulsions or seizures..... Yes No  
 Numbness or tingling..... Yes No  
 Tremors..... Yes No  
 Paralysis..... Yes No  
 Stroke..... Yes No  
 Head Injury..... Yes No  
 Any other..... Yes No

The above information is accurate to the best of my knowledge

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

I have reviewed the above information with the patient

\_\_\_\_\_  
Physician printed name & signature

\_\_\_\_\_  
Date