

Patient Health History

NAME: _____ DATE OF BIRTH: _____ AGE: _____
REFERRED BY: _____ PRIMARY DOCTOR: _____
REASON FOR TODAY'S VISIT: _____ TODAY'S DATE: _____

MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER):

Strength, Route, Frequency. Ex. Aspirin, 81 mg, 1 tablet by mouth daily

NON-STEROIDAL DRUG USE? ☐ YES ☐ NO
(Ex: Aleve, Ibuprofen, Motrin, etc.)

DO YOU TAKE ASPIRIN? ☐ YES ☐ NO

DO YOU USE HERBAL PRODUCTS? ☐ YES ☐ NO

DO YOU TAKE MULTIVITAMINS? ☐ YES ☐ NO

DO YOU TAKE BLOOD THINNERS? ☐ YES ☐ NO

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY):

- | | |
|--|---|
| ☐ HEART DISEASE | ☐ ASTHMA |
| ☐ DIABETES: _____ | ☐ ARTHRITIS |
| ☐ LUNG DISEASE/COPD | ☐ COLON POLYPS |
| ☐ HIGH BLOOD PRESSURE | ☐ COLON CANCER |
| ☐ KIDNEY DISEASE | ☐ SEIZURES/EPILEPSY |
| ☐ CELIAC DISEASE | ☐ GLAUCOMA |
| ☐ COLITIS/CROHN'S DISEASE | ☐ CONGESTIVE HEART FAILURE |
| ☐ STROKE | ☐ THYROID DISEASE |
| ☐ HEPATITIS/LIVER DISEASE | |
| ☐ CANCER – TYPE: _____ | |
| ☐ OTHER: _____ | |

FEMALES – IS THERE ANY CHANCE THAT YOU ARE PREGNANT? ☐ YES ☐ NO

ALLERGIES: Substance & Reaction

- ☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Have you ever had an unusual reaction to a general or local anesthetic? ☐ YES ☐ NO

Explain: _____

Have you ever received a blood or a blood-product transfusion?

☐ YES ☐ NO Year: _____

PREVIOUS SURGERIES/PROCEDURES (CHECK ALL THAT APPLY)

- | | |
|---|--|
| ☐ HERNIA | ☐ BACK |
| ☐ APPENDIX | ☐ TONSILS |
| ☐ GALLBLADDER | ☐ BREAST |
| ☐ HYSTERECTOMY | ☐ PACEMAKER IMPLANTED |
| ☐ TUBAL LIGATION | ☐ DEFIBRILLATOR IMPLANTED |
| ☐ HIP REPLACEMENT | ☐ KNEE REPLACEMENT |
| ☐ HEART BYPASS SURGERY | ☐ HEART VALVE REPLACED |
| ☐ EGD – DATE: _____ | |
| ☐ COLONOSCOPY – DATE: _____ | |
| ☐ COLON, INTESTINAL, STOMACH SURGERY – | |
| DATE: _____ | |
| ☐ OTHER: _____ | |

FAMILY HISTORY (CHECK ALL THAT APPLY):

- ☐ CELIAC DISEASE WHO: _____
- ☐ COLITIS/CROHN'S DISEASE WHO: _____
- ☐ COLON POLYPS WHO: _____
- ☐ COLON CANCER WHO: _____
- ☐ LIVER DISEASE/PROBLEMS WHO: _____
- ☐ CANCER WHO/TYPE: _____
- ☐ HIGH BLOOD PRESSURE WHO: _____
- ☐ KIDNEY DISEASE WHO: _____
- ☐ HEART DISEASE WHO: _____
- ☐ LUNG DISEASE WHO: _____
- ☐ DIABETES WHO: _____
- ☐ STROKE WHO: _____

SOCIAL HISTORY:

- MARITAL STATUS ☐ M ☐ S ☐ D ☐ W
- CAFFEINE ☐ YES ☐ NO QTY: _____
- SMOKE ☐ YES ☐ NO QTY: _____
- TATTOOS ☐ YES ☐ NO YEAR: _____
- OCCUPATION: _____
- ALCOHOL ☐ YES ☐ NO QTY: _____
- IV DRUG USE ☐ YES ☐ NO WHEN: _____
- Do you feel threatened, abused, neglected or exploited in your home? ☐ YES ☐ NO

REVIEW OF SYMPTOMS – PLEASE CHECK YES OR NO TO ALL QUESTIONS:**CONSTITUTIONAL:**

- WEIGHT LOSS ☐ YES ☐ NO
- WEIGHT GAIN ☐ YES ☐ NO
- FEVER ☐ YES ☐ NO
- CHILLS ☐ YES ☐ NO

EYES:

- REDNESS ☐ YES ☐ NO
- DOUBLE OR BLURRED VISION ☐ YES ☐ NO

ENT:

- HOARSENESS ☐ YES ☐ NO
- TROUBLE SWALLOWING ☐ YES ☐ NO

HEMATOLOGIC/LYMPHATIC:

- BRUISING ☐ YES ☐ NO
- BLOOD CLOTS ☐ YES ☐ NO
- ANEMIA ☐ YES ☐ NO

RESPIRATORY/CARDIOVASCULAR:

- EDEMA ☐ YES ☐ NO
- SHORTNESS OF BREATH ☐ YES ☐ NO
- CHEST PAIN ☐ YES ☐ NO

NEUROLOGICAL:

- HEADACHES ☐ YES ☐ NO
- DIZZINESS ☐ YES ☐ NO
- HISTORY OF FALLS ☐ YES ☐ NO
- OTHER: _____

GASTROINTESTINAL:

- NAUSEA ☐ YES ☐ NO
- VOMITING ☐ YES ☐ NO
- ACID REFLUX ☐ YES ☐ NO
- HEARTBURN ☐ YES ☐ NO
- DIARRHEA ☐ YES ☐ NO
- CONSTIPATION ☐ YES ☐ NO
- BLOOD IN STOOL ☐ YES ☐ NO
- ABDOMINAL PAIN ☐ YES ☐ NO
- ABDOMINAL BLOATING ☐ YES ☐ NO

MUSCULOSKELETAL:

- BACK PAIN ☐ YES ☐ NO
- CHEST PAIN ☐ YES ☐ NO
- WEAKNESS ☐ YES ☐ NO
- JOINT PAIN/SWELLING ☐ YES ☐ NO

UROLOGY:

- BLADDER PROBLEMS ☐ YES ☐ NO
- KIDNEY DISEASE ☐ YES ☐ NO

INTEGUMENTARY:

- SKIN RASH ☐ YES ☐ NO

PSYCHOLOGICAL:

- ANXIETY ☐ YES ☐ NO
- DEPRESSION ☐ YES ☐ NO
- MEMORY LOSS ☐ YES ☐ NO

PATIENT SIGNATURE: _____ DATE: _____

NURSE SIGNATURE: _____ DATE: _____

PROVIDER SIGNATURE: _____ DATE: _____