Patient Health History Form

Patient Name: ___________________________________ **Date of birth:** ______________________________

Adult Initial Visit (p1) Please provide the following medical information to the best of your ability:

Today's Date: **Age:**

What problems are you here for today?

____

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____

List any **ALLERGIES TO MEDICATIONS** with reactions:

____

____

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____

IF NO KNOWN DRUG ALLERGIES, CHECK HERE ☐

Past Medical History:

1)Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes please explain:

	YES	NO			YES	NO	
Diabetes	☐	☐	________________	Bleeding Disorder	☐	☐	___________________
Hypertension	☐	☐	________________	Allergy prob/Therapy	☐	☐	___________________
Thyroid problems	☐	☐	________________	Kidney problems	☐	☐	___________________
Heart disease/cholesterol	☐	☐	________________	Neurological problems	☐	☐	___________________
Respiratory prob/Asthma	☐	☐	________________	Anesthesia problems	☐	☐	___________________
Stomach/intestinal prob	☐	☐	________________	Hepatitis	☐	☐	___________________

OTHER MEDICAL DIAGNOSIS: ____

2)Please list any **operations/surgical procedures (and dates)** you have ever had (including tonsils & adenoids):

____

____

3)Please list any **current medications (including dosage, times per day)**:

(Include aspirin, antacids, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds)

____

____

Social History:	YES	NO	Please list details below
Do you smoke or chew tobacco?	☐	☐	**How much?** _____________**For how long?** ______________
If no, did you use tobacco in the past?	☐	☐	____
Do you have pets in your home?	☐	☐	____

How often do you drink alcohol? ____ **What type?** ______________

How often do you drink caffeine? ____

What is your occupation? Marital status?

____

Family History: Please check the "Yes" or "No" box to indicate whether any relatives have/had any of the following:

	YES	NO			YES	NO	
Hearing problems	☐	☐	__________________	Bleeding disorders	☐	☐	__________________
Allergies	☐	☐	__________________	Anesthesia prob.	☐	☐	__________________
Diabetes	☐	☐	__________________	Heart problems	☐	☐	__________________
Cancer	☐	☐	__________________				

REVIEWED BY STAFF:

Patient Name: ___________________________________ **Date of birth:** ___________________________________

Adult Initial Visit (p2) Please provide the following medical information to the best of your ability:

Review of Systems (only check the ones that pertain to you)

Category		Yes		Yes
General	Fatigue		Weight change	
Allergy/Immunology	Sneezing fits		Environmental Allergy	
Eye	Diminished visual acuity		Eye pain	
ENT	Snoring/Apnea		Sore throat	
Endocrine	Cold intolerance		Excessive sweating	
Respiratory	Shortness of breath		Wheezing	
Cardiovascular	Chest pain		Palpitations	
GI	Difficulty swallowing		Reflux/Heartburn	
Hem/Lym	Bleeding problems		Swollen glands	
Urinary	Blood in urine		Frequent Urination	
Musculoskeletal	Muscle Aches		Joint Aches	
Skin	Hives		Rash	
Neuro	Weakness		Headaches	
Psychological	Anxiety		Depression	

Medicare patients – have you had any of the following? (Please write month & year)

Flu shot: _________________________ **Pneumonia shot:** _________________________

Colonoscopy: _____________________ **Mammogram:** ___________________________