

**Patient Health History Form**

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

Please circle one: Miss/ Mrs./ Ms./ Mr./ Dr./ Rev.

Name Preferred to be called: \_\_\_\_\_

Age: \_\_\_\_\_

Date: \_\_\_\_\_

Which doctor sent you today?

Name of your family doctor?

Please list other doctors that you see

(Please include phone number and addresses)

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**Prescription Medicines**

Drug Name

Dose

Frequency

For What

Who Prescribed

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**Over the Counter (OTC) Medicines/ Herbal Supplements/ Vitamins you are taking**

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Pharmacy Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Medicine Allergies**

Drug Name

What happens to you when you take it?

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## **Medical History**

**Please circle past illnesses or chronic medical problems which apply to you:**

- Asthma, Pneumonia, COPD, Tuberculosis
- Hypertension, Heart Attack, Congestive Heart Failure, Irregular Heart Beat
- Recurrent Urinary Tract Infections, Kidney Stones, Blood In Urine, Kidney Disease
- Constipation, Diarrhea, Crohn's Disease, Ulcerative Colitis, Colon Polyps, Peptic Ulcer Disease, Reflux Disease
- Hepatitis, Cirrhosis of Liver, Gall Bladder Disease
- Migraine Headaches, Seizure Disorder, Peripheral Neuropathy, Multiple Sclerosis, Stroke
- Osteoarthritis, Rheumatoid Arthritis, Lupus
- Anemia, Thyroid Disease, Diabetes
- Depression, Bipolar Disorder

## **Past Operations**

**Type**

**Date**

**Hospital or Clinic**

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**If you are here regarding a clotting problem please complete the following:**

- Blood clot in leg
- Blood clot in arm
- Pulmonary Embolism
- Blood clot other \_\_\_\_\_
- Stroke
- Pre-Stroke symptoms (TIA's)

**Women:**       Miscarriage      **How Many?** \_\_\_\_ **Trimester** 1 / 2 / 3

**Family History of:**

- Blood clot: Who \_\_\_\_\_
- Miscarriage: Who \_\_\_\_\_
- Pulmonary Embolism: Who \_\_\_\_\_
- Stroke: Who \_\_\_\_\_

**If you are here regarding a bleeding problem please complete the following:**

- Bleeding with tooth extraction**
- Required “packing” for bleeding with tooth extraction**
- Nose bleeds Spontaneous? Yes / No**
- Urinary bleeding**
- Rectal Bleeding**
- Bleeding with colonoscopy**
- Bleeding with surgery**

**Women:**

- Heavy periods**
- Post-partum bleeding (severe)**
- Require dilation and curettage because of bleeding**
- Require hysterectomy because of bleeding**

**Men/Women:**

- Prior blood transfusion**                      **If yes, explain circumstances:**

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- Other bleeding issues:**

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- Family History of Bleeding Disorder**                      **If yes, please describe:**

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**Last Colonoscopy:**

**Date:** \_\_\_\_\_

**Polyps:**

**Yes   or   No**

**Reproductive History (for females):**

**Last Mammogram:**

**Date:** \_\_\_\_\_

**Biopsies:**

**Yes   or   No**

**Pap Smears:**

**Date:** \_\_\_\_\_

**Abnormal Pap:**

**Yes   or   No**

Your age when periods began: \_\_\_\_\_ Date of your last period: \_\_\_\_\_  
Total pregnancies you've had: \_\_\_\_\_ Age at first childbirth: \_\_\_\_\_  
How many children born alive: \_\_\_\_\_ Miscarriages or Abortions: \_\_\_\_\_  
Did you have medical problems associated with pregnancy or with any other gynecological illnesses?

Have you used post-menopausal hormones? \_\_\_\_\_ How long? \_\_\_\_\_  
Did you nurse your child(ren)? \_\_\_\_\_ How long? \_\_\_\_\_

Marital Status: (circle one that applies) Single / Married / Widowed / Divorced

Occupation (if retired, former occupation): \_\_\_\_\_

Do you smoke? Yes / No If yes: \_\_\_\_\_ packs per day \_\_\_\_\_ years \_\_\_\_\_  
If no, did you use to smoke? Yes / No

Alcohol Use: Yes / No # of drinks \_\_\_\_\_ per (circle one) week / month

**Family History of Cancer**

	What Kind	Age at diagnosis
Mother	_____	_____
Father	_____	_____
Brother(s)	_____	_____
Sister(s)	_____	_____
Pat. Grandmother	_____	_____
Pat. Grandfather	_____	_____
Mat. Grandmother	_____	_____
Mat. Grandfather	_____	_____
Son(s)	_____	_____
Daughter(s)	_____	_____
Other	_____	_____

Do you have any specific religious or cultural beliefs which may impact your health care?

\_\_\_\_\_  
\_\_\_\_\_

How did you hear of this office?

- |   |  |
|---|--|
| <input type="checkbox"/> Website            | <input type="checkbox"/> Internet                          |
| <input type="checkbox"/> Physician Referral | <input type="checkbox"/> Family / Friend                   |
| <input type="checkbox"/> Relay for Life     | <input type="checkbox"/> Living Magazine                   |
| <input type="checkbox"/> Radio Ad           | <input type="checkbox"/> Other Ad – please describe: _____ |
| <input type="checkbox"/> Other: _____       |  |