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Patient Health History Form

It is the patient's responsibility to provide complete, accurate information when completing this form. Signature is required below.

Patient Name (First, Last, MI) _____

Date of Birth (mm/dd/yyyy) _____ Are you here due to a work related injury? Y ___ N ____
Family Doctor Name: _____ Date of Last Visit (mm/dd/yyyy) ___/___/____

Please describe the reason for your visit today: _____
Employed? Yes / No If yes Do you stand on your feet all day? Yes / No What type of job do you do? _____

CURRENT MEDICATIONS (List all medications you are currently taking)

_____

_____

ALLERGIES (List all allergies, if no allergies write NONE)_____

SOCIAL HISTORY
Smoker? Yes___ How Much? _____ No___ Quit___ When? _____
Drink Alcohol? Yes ___ How Much? _____ No ___ Drug Use or Abuse? Yes ___ No ___ Marital Status S / M / W / D

PAST MEDICAL and FAMILY HISTORY
Please indicate if you or a family member have had any of the following (indicate **M**other, **F**ather, **S**ister, **B**rother).

Self	Family (list M,F,S,B)	Self	Family (list M,F,S,B)	Self	Family (list M,F,S,B)
___	_____ Heart Attack/Angina	___	_____ Lupus	___	_____ Gout
___	_____ Heart Disease/Murmur/Failure	___	_____ Cancer _____	___	_____ Asthma/Hay Fever
___	_____ High Blood Pressure	___	_____ Emphysema / Home Oxygen	___	_____ HIV / Tuberculosis
___	_____ High Cholesterol	___	_____ Pneumonia / COPD	___	_____Thyroid disease
___	_____ Glaucoma/Eye disease	___	_____ Phlebitis (blood clot)	___	_____ Diabetes – ID / NID
___	_____ Kidney Disease/ stones	___	_____ Prostate Problems	___	_____ Neuropathy _____
___	_____ Gall Stones	___	_____Stroke	___	_____ Liver Disease
___	_____ Bleeding Tendencies	___	_____Acid reflux/ Gerd	___	_____ Depression
___	_____ Hepatitis if yes, type ____	___	_____ Rheumatoid / Osteoarthritis	___	_____ Fibromyalgia
___	_____ Seizure/Convulsions	___	_____ Osteoporosis	___	_____ PVD

SURGICAL HISTORY Check if you have had any of the following surgeries.

___ Hip Replacement	___ Neck	___Tonsils/Adenoids	___ Foot RT / LT
___ Knee Replacement	___ Back	___ Breast	___ Ankle RT / LT
___ Arthroscopy _____	___ Appendectomy	___ Hernia	___ Heart _____
___ Hysterectomy/D&C/Tubal	___ Eye/Cataract	___ Gallbladder	___Other _____
___ Hand / Carpal Tunnel	___Shoulder / Rotator cuff	___ Colonoscopy	___Other _____

REVIEW of SYSTEMS Circle **Y**es or **N**o if you have a problem with any of the following systems:

Constitutional (General Health)	Y N	Skin	Y N	Endocrine	Y N
Ears/Nose/Throat	Y N	Psychiatric	Y N	Neurological	Y N
Cardiovascular	Y N	Gastrointestinal	Y N	Respiratory	Y N
Blood Disorder	Y N	Eyes	Y N	Urinary/Genital	Y N
Allergy/Immunologic	Y N	Musculoskeletal	Y N		

Patient Signature:_____ **Date:** _____/_____/_____

Physician Signature:_____ **Date:**_____/_____/_____ **MRN** _____

DO NOT COMPLETE THIS SECTION (OFFICE USE) Chief Complaint: ***NEW PATIENT or ANNUAL UPDATE*** ***Alert added*** ____

_____

_____

Other Doctor Seen For this Problem: _____ Date last seen for problem: ____/___/____
Accident YES____ NO_____ If yes, DOI/Onset Date ____/____/_____ Accident Location_____
Height: _____ Weight: _____ Blood Pressure _____/_____ Pulse _____ Respiration: _____