HEALTH HISTORY SHEET

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Last Name:	First:	Age:	Gender:	**PROVIDER NOTES** Please do not write in this area

Reason for today's visit:

PAST ILLNESS: Please indicate if you have been diagnosed with these conditions:

	Y	N		Y	N
High blood pressure			Migraine headaches		
Angina/chest pain			Epilepsy		
Heart attack			Stroke		
Heart murmur			Glaucoma		
Irregular heart rate			Ulcers		
Asthma			Gallstones		
Emphysema			Diverticulitis		
Tuberculosis			Hepatitis		
Diabetes			Cancer (elaborate below)		
Thyroid disease			Osteoporosis		
Kidney disease/failure			Mental illness		

Please indicate other known medical problems:

Please list operations that you have had

Operation:	**Year:**

	Y	N
Have you ever had any bleeding problems?		
Have you ever had a blood transfusion?		
Have you had any anesthesia problems?		
Do you have any metal implants?		

Patient Name:

DRUG ALLERGIES: Please list medication and reaction No known drug allergy ☐

Name of drug	Reaction

Do you have an allergy to LATEX? ☐ yes ☐ no

MEDICATIONS: PLEASE LIST ALL CURRENT MEDICATIONS WITH DOSAGE AND FREQUENCY
EXAMPLE: METFORMIN 10MG TWICE A DAY

NAME OF DRUG	DOSE	FREQUENCY
EXAMPLE: METFORMIN	***10MG***	***TWICE A DAY***

	Y	N
Do you take aspirin or Plavix?		
Do you take ibuprofen or other anti-inflammatory medications frequently?		
Do you take a blood thinning medication?		

PERSONAL HABITS/RISK FACTORS:

Do you smoke? ☐ yes ☐ no How many packs/day?

Have you ever smoked? ☐ yes ☐ no Date stopped:

Do you drink alcohol? ☐ yes ☐ no Frequency? Amount?

FAMILY HISTORY (please indicate conditions such as heart disease, stroke, cancer, blood disorders):

SOCIAL HISTORY:

Are you: ☐ married ☐ divorced ☐ single ☐ widowed

Who do you live with?

Do you have a living will? yes ☐ no ☐

Are there any special concerns you would like to discuss? If so, please continue on the reverse.

PROVIDER NOTES
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Patient Name:

REVIEW OF SYSTEMS: Please indicate all that apply to you

Constitutional symptoms	Y	N	**Head and Neck**	Y	N
Weight gain/loss			Dizziness/vertigo		
Fevers			Double vision		
Night Sweats			Any vision changes		
Fatigue			Nose bleeds		
Loss of appetite			Sore throat/pain swallowing		
Cardiac	Y	N	**Respiratory**	Y	N
Chest pain/heaviness			Cough		
Shortness of breath with activity			Wheeze		
Shortness of breath at rest			Shortness of breath		
Irregular heart beat/palpitations			Blood in sputum		
Lightheadedness/fainting			Early waking/snoring		
Gastrointestinal	Y	N	**Genitourinary**	Y	N
Abdominal pain			Frequent voiding		
Nausea/vomiting			Pain with voiding		
Heartburn			Blood in urine		
Constipation or diarrhea			Sexual dysfunction		
Blood with stools			Groin pain		
Endocrine	Y	N	**Hematologic**	Y	N
Heat/cold intolerance			Abnormal bleeding/bruising		
Excessive thirst			Clotting problems		
Excessive voiding			Transfusion problems		
Excessive appetite			Anemia		
Excessive hair growth			Blood clots		
Musculoskeletal	Y	N	**Neuro-psychiatric**	Y	N
Joint pain/swelling			Seizures		
Stiffness			Numbness		
Weakness of limbs			Weakness		
Back pain/sciatica			Depression		
Gout			Anxiety		
ObGyn	Y	N	**Breast Health**	Y	N
Pregnancies? Live births			Breast cysts/lumps		
C-section?			Breast skin changes		
Menstrual period regular/irreg			Nipple discharge		
Postmenopausal			Breast pain		
Recent PAP smear			Recent mammogram		

PROVIDER NOTES

Please do not write in this area

Thank you for providing us with this important information

Signature: _____ ***Date:*** _____