



Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring doctor/person \_\_\_\_\_

\*Reason for this visit: \_\_\_\_\_

Do you have pain related to this condition? NO YES, describe \_\_\_\_\_

**ALLERGIES**

Do you have allergies to medicines? NO YES, list allergies \_\_\_\_\_

Do you have allergies to latex products such as exam gloves or balloons? NO YES

**MEDICATIONS**- Please list all of the prescription, over the counter & herbal medicines you take.

I take no prescription, herbal or over the counter medications.

Prescription Medicines	Prescription Medicines	Over the Counter & Herbal

**MEDICAL HISTORY**- Please list all previous health problems.

PROBLEM	No	Yes	When	Describe
Heart Disease				
High Blood Pressure				
Diabetes				
Cancer				
Circulation Problems				
Respiratory / Lung Problems				
Stomach/ Intestine Problems				
Bleeding/ Clotting Problems				
Neurological Problems				
Infectious ( TB, hepatitis, HIV, VRE)				
Glaucoma/ Cataracts				
Broken Bones/ Orthopedic				
Ear Problems/ Hearing Loss				
Endocrine Problems (ie: thyroid)				
Anesthesia Problems				
Other Problems				

**PAST SURGERIES** - Please list

I have never had surgery.

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**PAST HOSPITALIZATIONS** - Please list

I have never been hospitalized.

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**ADVANCE DIRECTIVES** Do you have an advance directive? *(This section to be completed by adult patients only)*

Yes. What type? Health care proxy living will DNR other: \_\_\_\_\_  
No, I would like more information No, I am not interested in more information at this time

**ENVIRONMENTAL HISTORY**

Do you or did you ever smoke? NO YES: Date started: \_\_\_\_\_ date quit: \_\_\_\_\_ # packs per day \_\_\_\_\_  
Do you chew tobacco? NO YES  
Do you drink alcohol? NO YES: How many drinks do you have in a typical week? \_\_\_\_\_  
Do you use recreational or street drugs? NO YES, describe \_\_\_\_\_

**SOCIAL HISTORY**

Living situation: Child Single Married Widowed Separated Divorced  
Number of family members living at home (include yourself): \_\_\_\_\_ Adults \_\_\_\_\_ Children \_\_\_\_\_ Grandchildren  
Are you a caregiver for a family member at home? NO YES  
What is the highest grade of school you have completed? Give grade or degree:  
\_\_\_\_\_ Child \_\_\_\_\_ Elementary \_\_\_\_\_ Jr. High \_\_\_\_\_ High School \_\_\_\_\_ College \_\_\_\_\_ Post graduate  
Your occupation: \_\_\_\_\_ status: \_\_\_\_\_ retired \_\_\_\_\_ full time \_\_\_\_\_ part-time \_\_\_\_\_ unemployed

**FAMILY HISTORY:** Please check all that apply

<b>DISEASE</b>	<b>Mother</b>	<b>Father</b>	<b>Mother's Parents</b>	<b>Father's Parents</b>	<b>Brothers &amp; Sisters</b>	<b>Children</b>
Heart Disease						
High Blood Pressure						
Cancer						
Respiratory Disease						
Hearing Loss						
Glaucoma						
Diabetes						
Bleeding Disorders						
Thyroid Disease						
Mental Illness						
Anesthesia Reaction						
Neuromuscular Disease						
Other Significant Illness						

**REVIEW OF SYSTEMS** *(Please circle all that apply)*

Do you...

**Eyes-** wear glasses or contacts? have cataracts, glaucoma, vision loss, blurry vision, double vision?

**Ears-** wear hearing aids? have hearing loss, ringing in the ears, dizziness or balance problems, ear pain, drainage?

**Nose and Sinus-** have nasal blockage, nose bleeds, frequent sinus infections, post nasal drip, hay fever, allergies?

**Speaking and swallowing-** have difficulty chewing or swallowing, problems speaking, hoarseness, mouth/ throat pain?

**Respiratory- use oxygen?** have shortness of breath, chronic cough, wheezing?

**Cardiac-** have chest pain, enlarged heart, heart failure, irregular heartbeat murmurs, pacemaker?

**Gastrointestinal-** have bleeding ulcers, hiatal hernia, reflux, diverticulitis, polyps, hemorrhoids, anorexia, weight loss?

**Kidney and bladder-** have frequent urination, burning , painful , blood in urine, kidney stones, enlarged prostate?

**Neurological** –migraines, paralysis, weakness, numbness, tingling in arms or legs, seizures, Bell’s palsy?

**Vascular-** have vein problems, blood clots, narrowed vessels, calf pain with walking?

**Hematological & Lymphatic-** have anemia, bleeding problems, easy bruising, thin blood, swollen nodes?

**Skin-** have rashes, frequent itching, sores that won’t heal, infections or boils, skin lesions?

**Endocrine-** thyroid problems, weight loss or gain, excessive sweating, tremor?

**Additional comments-**

Thank you for completing this form. A complete and accurate health history is important for us to provide you with the best care.