PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible.
PLEASE READ AND COMPLETE EVERY SECTION.

Full Name _____ **Appointment Date** _____

SSN# _____ Male ☐ Female ☐ Date of Birth _____

Pharmacy Preference (not mail-in, include location) _____

Name of Primary Care Physician _____ Name of Referring Physician _____

CURRENT MEDICATIONS

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)
☐ No ☐ Yes. If yes, please list below (***include dosages***).

Medication Name	Dosage	How often taken

MEDICATION ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ No ☐ Yes If yes, please list below.

Name of Medication	Type of reaction

NON-MEDICATION ALLERGIES

Are you allergic to any type of food? ☐ No ☐ Yes
If yes, what foods _____ (Type of reaction _____)
Are you allergic to anything that touches your skin? ☐ No ☐ Yes
☐ latex (Type of reaction _____) ☐ tape (Type of reaction _____) ☐ metal (Type of reaction _____)
Are you allergic to contrast dye? ☐ No ☐ Yes

PAST HEALTH HISTORY

Have you ever been *DIAGNOSED* with any of the following problems?

Head and Face:
Migraine headache ☐ **No** ☐ **Yes**
Eyes:
Cataracts ☐ **No** ☐ **Yes**
Glaucoma ☐ **No** ☐ **Yes**
Ears:
Hearing loss from aging ☐ **No** ☐ **Yes**
Hearing loss from trauma ☐ **No** ☐ **Yes**
Heart and Blood Vessels:
Heart Murmur / MVP ☐ **No** ☐ **Yes**
Anemia ☐ **No** ☐ **Yes**
High Elevated Cholesterol ☐ **No** ☐ **Yes**
High Blood Pressure ☐ **No** ☐ **Yes**
CHF ☐ **No** ☐ **Yes**
Lungs, Respiratory ☐ **No** ☐ **Yes**
Asthma ☐ **No** ☐ **Yes**
Chronic Bronchitis ☐ **No** ☐ **Yes**
Emphysema ☐ **No** ☐ **Yes**
Tuberculosis ☐ **No** ☐ **Yes**
COPD ☐ **No** ☐ **Yes**

Stomach and Digestive:
Cholecystitis (gallbladder inflammation) ☐ **No** ☐ **Yes**
Gastrointestinal reflux ☐ **No** ☐ **Yes**
Stomach Ulcer ☐ **No** ☐ **Yes**
Ulcerative colitis ☐ **No** ☐ **Yes**
Mental & Emotional:
Depression ☐ **No** ☐ **Yes**
Anxiety ☐ **No** ☐ **Yes**
Glands, Hormones, and Sugar Control:
Diabetes ☐ **No** ☐ **Yes**
Thyroid Dysfunction ☐ **No** ☐ **Yes**
Immune & Infectious Problems: ☐ **No** ☐ **Yes**
Hepatitis
If yes, what type ☐A ☐B ☐C
HIV ☐ **No** ☐ **Yes**
Infectious mononucleosis ☐ **No** ☐ **Yes**
Cancer ☐ **No** ☐ **Yes** **List Type** _____
Other (not listed) _____

NEXT PAGE

PATIENT NAME: _____

SURGERIES AND HOSPITALIZATIONS

Have you had problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes
If yes, what type ofproblem? _____ Type of anesthesia? _____

List any surgeries you have had _____

_____

Have you ever been hospitalized for non-surgical reasons? ☐ No ☐ Yes
If so, please explain. _____

Are you pregnant or think you might be? ☐ No ☐ Yes

FAMILY HISTORY

Specific Anesthesia Problem ☐Mother ☐Father ☐Brother ☐Sister
Ears:
Hearing Loss before age 20 ☐Mother ☐Father ☐Brother ☐Sister
Hearing Loss after age 20 ☐Mother ☐Father ☐Brother ☐Sister
Nose and Sinus:
Chronic Sinus Disease ☐Mother ☐Father ☐Brother ☐Sister
Heart and Blood Vessels:
Heart Disease ☐Mother ☐Father ☐Brother ☐Sister
High Blood Pressure ☐Mother ☐Father ☐Brother ☐Sister
Lungs and Respiratory:
Asthma ☐Mother ☐Father ☐Brother ☐Sister
Lung Cancer ☐Mother ☐Father ☐Brother ☐Sister
Brain and Nervous:
Stroke ☐Mother ☐Father ☐Brother ☐Sister
Blood & Lymph Node problems
Bleeding/clotting problem ☐Mother ☐Father ☐Brother ☐Sister
Allergies, Immune and Infectious problems:
Allergies requiring treatment ☐Mother ☐Father ☐Brother ☐Sister
Other _____

SOCIAL HISTORY

What is or was your occupation? _____ ☐**Check here if you are retired.**
Have you ever used tobacco in any form? ☐**No** ☐**Yes** **Do you consume alcohol?** ☐**No** ☐**Yes**
If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type) _____		

Type of Alcohol	How much	How often

Are you exposed to second hand smoke? ☐ No ☐ Yes
Do you use drugs recreationally? ☐ No ☐ Yes If yes, please list _____
How much caffeine do you consume? ☐ none ☐ 1 drink per day ☐ 2-3 drinks per day ☐ more than 3 drinks per day

REVIEW OF SYSTEMS: Mark **YES or NO and CHECK any of the following you have recently had.**

General health problems ☐ No ☐ Yes
❑fever, ❑ sleeping problems,
❑ unintentional weight loss, ❑sleep apnea

Eye problems ☐ No ☐ Yes
❑blurred vision, ❑ itchy eyes (frequent), ❑ loss of vision, ❑ painful eye

Ear problems ☐ No ☐ Yes
❑ ear drainage, ❑ hearing loss, ❑ dizziness, ❑ ringing, ❑ painful ear, ❑ use of hearing aid

Nose & Sinuses ☐ No ☐ Yes
❑frequent runny nose, ❑ post nasal drainage, ❑ nasal congestion, ❑ recurrent infections, ❑ nose bleeds

Mouth & Throat problems ☐ No ☐ Yes
❑ bad breath, ❑ change in voice, ❑ snoring, ❑ sore throat, ❑ trouble swallowing, ❑ ulcers, ❑chronic tonsillitis

Heart or Circulation problems ☐ No ☐ Yes
❑ blacking out or fainting, ❑ chest pain, ❑ irregular heartbeat, ❑ swelling of ankles ❑other _____

Lung or Respiratory problems ☐ No ☐ Yes
❑freq non-productive cough, ❑ freq productive cough, ❑ shortness of breath, ❑ wheezing, ❑other _____

Stomach problems ☐ No ☐ Yes
❑abdominal pain, ❑diarrhea, ❑heartburn, ❑nausea, ❑vomiting, ❑other _____

Bones, Joints and Muscles ☐ No ☐ Yes
❑pain in back, ❑painful joints, ❑stiffness, ❑swelling of joints

Head, Face, Brain or Nervous System problems ☐ No ☐ Yes
❑change in alertness, ❑loss of bladder control, ❑loss of consciousness, ❑severe face pain, ❑headaches, ❑numbness, ❑weakness

Problems with Glands, Hormones ☐ No ☐ Yes
❑increased appetite, ❑increased fatigue, ❑neck has enlarged, ❑ unwanted weight change

Problems with Blood or Lymph Nodes ☐ No ☐ Yes
❑ bleeds excessively after injury, ❑ bruises easily ❑clotting disorder, ❑masses or lumps in neck, ❑swollen glands

Problems with Allergies ☐ No ☐ Yes
❑food intolerances, ❑ freq sneezing, ❑ hives, ❑ severe reaction to insect bites

Other (not listed) _____

What is the main reason you are seeing the doctor today? _____