Health History Intake Form

Your physician today:

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☐

Today's Date:_____

Patient Name:_____

Date of Birth:_____ **Age:**_____

Previous Primary Care Physician (if any):_____

Phone:_____ **Address:**_____

Other Physicians involved in your care:_____

_____

Reason for visit today:

_____

_____

_____

Allergies (Medication/Food, indicate reaction): ☐ None

_____
_____
_____

Medication List: (Please list name/dose/frequency if known)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family History: (please indicate deceased or alive, medical issues and age)

Father:_____
Mother:_____
Siblings:_____
_____
Grandparents:_____

Habits:

Alcohol: ☐ None ☐ Yes: How many drinks/day _____frequency/week _____What kind_____
Tobacco: ☐ None ☐ Yes: Chew or smoke?_____ How many/day _____ since_____
Caffeine: ☐ None ☐ Yes: What kind_____ How many/day _____
Other Recreational Drugs: ☐ None ☐ Yes: What kind_____ How many/day _____
Do you drive? ☐ Yes ☐ No Do you always wear a seatbelt? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No If yes, how much?_____

Social History:

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled
Current Occupation _____Former Occupation _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Domestic Partner
Sexual preference: ☐ Men ☐ Women ☐ Both
Children (age):_____
Hobbies:_____
Sports:_____
Pets:_____
Other:_____

Past Surgical History (indicate date if known)

- ☐ None
- ☐ Cataracts_____
- ☐ LASIK_____
- ☐ Tonsillectomy_____
- ☐ Thyroidectomy_____
- ☐ Adenoidectomy_____
- ☐ Coronary Bypass_____
- ☐ Cardiac Stents_____
- ☐ Pacemaker_____
- ☐ Heart Valve_____
- ☐ Gall Bladder_____
- ☐ Appendectomy_____
- ☐ Bowel/Stomach Resection_____
- ☐ Hemorrhoidectomy_____
- ☐ Bariatric surgery_____
- ☐ Hysterectomy_____
- ☐ Endoscopy_____
- ☐ Colonoscopy_____
- ☐ Hernia_____
- ☐ Spinal Surgery_____
- ☐ Tubal Ligation_____
- ☐ Bladder surgery_____
- ☐ Prostate surgery/resection_____
- ☐ C-Section_____
- ☐ Orthopedic/joints_____
  _____
- ☐ Other_____
  _____

_____
_____
_____
_____

Past Medical History:

Head Aches	☐ Yes	☐ No	Date: _____
Stroke	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Pneumonia	☐ Yes	☐ No	_____
Diabetes (Type 1 or Type 2)	☐ Yes	☐ No	_____
Thyroid Disease (Low or High)	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____
Macular Degeneration	☐ Yes	☐ No	_____
Hearing Loss	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Blood Clots	☐ Yes	☐ No	_____
☐ Pulm Emboli (lung clots)	☐ Yes	☐ No	_____
☐ DVT (leg clots)	☐ Yes	☐ No	_____
Heart Burn, Reflux	☐ Yes	☐ No	_____
Stomach Ulcers	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
☐ Coronary Disease	☐ Yes	☐ No	_____
☐ MI/heart attacks	☐ Yes	☐ No	_____
☐ Congestive Heart Failure	☐ Yes	☐ No	_____
☐ Atrial Fibrillation	☐ Yes	☐ No	_____
☐ Angina	☐ Yes	☐ No	_____
☐ Valve Disorder	☐ Yes	☐ No	_____
High Cholesterol	☐ Yes	☐ No	_____
Gastrointestinal Bleeding	☐ Yes	☐ No	_____
Hepatitis (A, B, C)	☐ Yes	☐ No	_____
HIV / AIDS	☐ Yes	☐ No	_____
Chronic Wounds	☐ Yes	☐ No	_____
Cancer (type)	☐ Yes	☐ No	_____
Urinary Tract Infections	☐ Yes	☐ No	_____
Incontinence	☐ Yes	☐ No	_____
Kidney Stones	☐ Yes	☐ No	_____
COPD (Emphysema, Bronchitis)	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Bipolar Disorder	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Fibromyalgia	☐ Yes	☐ No	_____
Chronic Fatigue Syndrome	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Gout	☐ Yes	☐ No	_____
Osteoporosis	☐ Yes	☐ No	_____
Prostate Disease	☐ Yes	☐ No	_____
Breast Disease	☐ Yes	☐ No	_____
Erectile Dysfunction	☐ Yes	☐ No	_____

Other_____

Review of Systems (√ Yes or No for symptoms in past 6 months, circle for symptoms TODAY)

Constitutional/Endocrine

☐ Yes ☐ No **Fever**
☐ Yes ☐ No **Chills**
☐ Yes ☐ No **Weakness/Fatigue**
☐ Yes ☐ No **Weight Loss**
☐ Yes ☐ No **Weight Gain**
☐ Yes ☐ No **Insomnia**
☐ Yes ☐ No **Snoring**
☐ Yes ☐ No **Excessive thirst**
☐ Yes ☐ No **Excessive urination**
☐ Yes ☐ No **Cold or Heat intolerance**
Other:_____

HEENT

☐ Yes ☐ No **Sore Throat**
☐ Yes ☐ No **Stiff neck**
☐ Yes ☐ No **Change in your voice**
☐ Yes ☐ No **Sinus Drainage**
☐ Yes ☐ No **Sinus Head Ache**
☐ Yes ☐ No **Nose Bleeds**
☐ Yes ☐ No **Ear ache/drainage**
☐ Yes ☐ No **Hearing Loss**
☐ Yes ☐ No **Ringing in your ears**
☐ Yes ☐ No **Blurred Vision/Loss**
☐ Yes ☐ No **Wear glasses or contacts**
☐ Yes ☐ No **Itchy/watery eyes**
☐ Yes ☐ No **Dental problems**
Other:_____

Gastrointestinal

☐ Yes ☐ No **Nausea /Vomiting**
☐ Yes ☐ No **Difficulty swallowing**
☐ Yes ☐ No **Hemorrhoids**
☐ Yes ☐ No **Diarrhea**
☐ Yes ☐ No **Constipation**
☐ Yes ☐ No **Bloody or Black Stools**
☐ Yes ☐ No **Abdominal pain**
☐ Yes ☐ No **Heart burn/indigestion**
☐ Yes ☐ No **Frequent use of Laxatives**
Other:_____

Urinary

☐ Yes ☐ No **Pain or burning with urination**
☐ Yes ☐ No **Urinary frequency (Night or Day)**
☐ Yes ☐ No **Blood in urine / Dark urine**
☐ Yes ☐ No **Incontinence**
☐ Yes ☐ No **Slow starting or stopping urine**
Other:_____

Genital/Sex Organs

☐ Yes ☐ No **Penile discharge**
☐ Yes ☐ No **Testicular lump/pain**
☐ Yes ☐ No **Breast Pain/discharge/lump**
☐ Yes ☐ No **Painful intercourse**
☐ Yes ☐ No **Lack of sexual desire**
☐ Yes ☐ No **Problems with performance**
Other:_____

FEMALE Reproductive

☐ Yes ☐ No **Hot Flashes**
☐ Yes ☐ No **Bleeding after menopause**
☐ Yes ☐ No **Excessive menstrual bleeding**
☐ Yes ☐ No **Unusual vaginal discharge**
Age at onset of menstruation_____
1st day of last menstruation_____
☐ Yes ☐ No Menstrual pain/cramps
☐ Yes ☐ No Spotting between periods
Last pap smear:_____
Results:_____
Total Pregnancies:_____
Total live births:_____
Total miscarriages:_____
Total abortions:_____
Total C-sections:_____

Cardiac

☐ Yes ☐ No **Chest pain**
☐ Yes ☐ No **Palpitation**
☐ Yes ☐ No **Irregular heartbeat**
☐ Yes ☐ No **Exercise intolerance**
☐ Yes ☐ No **Leg swelling**
Other:_____

Respiratory

☐ Yes ☐ No **Persistent Cough**
☐ Yes ☐ No **Coughing up blood**
☐ Yes ☐ No **Shortness of breath**
☐ Yes ☐ No **Wheezing**
☐ Yes ☐ No **Can't breathe laying flat**
Other:_____

Skin

☐ Yes ☐ No **Rashes/Hives**
☐ Yes ☐ No **Skin discoloration**
☐ Yes ☐ No **Lesions/moles/warts**
☐ Yes ☐ No **Ulcers**
☐ Yes ☐ No **Itching**
☐ Yes ☐ No **Nail Problems**
☐ Yes ☐ No **Unusual Hair loss**
☐ Yes ☐ No **Easy bruising**
Other:_____

Psych

☐ Yes ☐ No **Depressed mood**
☐ Yes ☐ No **Suicidal thoughts/plans**
☐ Yes ☐ No **Agitation/irritability**
☐ Yes ☐ No **Insomnia**
☐ Yes ☐ No **Anxiety**
☐ Yes ☐ No **Frequent crying spells**
Other:_____

Musculoskeletal

☐ Yes ☐ No **Joint pains or stiffness**
☐ Yes ☐ No **Joint swelling**
☐ Yes ☐ No **Muscle weakness**
☐ Yes ☐ No **Back pain**
☐ Yes ☐ No **Muscle spasms/cramps**
☐ Yes ☐ No **Falling**
Other:_____

Neurologic

☐ Yes ☐ No **Frequent Headache**
☐ Yes ☐ No **Seizures**
☐ Yes ☐ No **Syncope (passing out)**
☐ Yes ☐ No **Limb weakness**
☐ Yes ☐ No **Limb numbness**
☐ Yes ☐ No **Dizziness**
☐ Yes ☐ No **Swallowing difficulty**
☐ Yes ☐ No **Balance issues**
☐ Yes ☐ No **Tremors**
☐ Yes ☐ No **Rigidity**
Other:_____
_____
_____