Patient Health and History Review

Date: ______________________

Name: _______________________________________ DOB: ____________ Age: ________

Gender: M F Other_________________ Marital Status: ____________________________

Telephone: Cell: ________________ Home: ___________________ Work: _______________

Email: ____

Home address: ____

Name of physician(s)	Specialty	Phone number	Date of Physical/ Last Seen

Family history (mother, father, brother, sister, grandparents)

❑ High Blood Pressure	❑ Diabetes	❑ High Cholesterol
❑ Heart Attack	❑ Stroke	❑ Kidney Disease
❑ Depression	❑ Other psychiatric condition	❑ Other

Past Medical History **Past Surgical History**

Past Medical History		Past Surgical History
❑ Asthma	❑ Chronic pain	❑ Appendectomy
❑ Allergies	❑ High Blood Pressure	❑ Angioplasty/stent
❑ Anemia	❑ Heart Attack	
❑ Arrhythmia (irregular heartbeat)	❑ Insomnia (difficulty sleeping)	❑ CABG (cardiac bypass)
❑ Atrial fibrillation	❑ GERD/Acid Reflux	❑ Hip/joint replacement
❑ Anxiety	❑ Osteoporosis/Osteopenia	❑ Hysterectomy
❑ Arthritis	❑ Ulcers, stomach	❑ Pacemaker/defibrillator
❑ Autoimmune disease	❑ Ulcers, intestine	❑ Live births #______
❑ Bowel disease	❑ Thyroid Disease	❑ Other
❑ COPD	❑ Stroke	
❑ Diabetes	❑ Constipation	
❑ Depression	❑ Diarrhea	
❑ High Cholesterol	❑ Infectious diseases	
❑ Cancer	❑ Other	

Current weight: _______________ **Desired weight:** _______________ **Height:**__________

Allergies and reactions (include medication and food):

Agent causing allergic reaction: - **Medication** - **Food** - **Environmental**	***Describe the reaction*** - **Allergic:** rash, hives, anaphylaxis - **Side effect:** nausea, vomiting, constipation, sleepiness, dizziness, stomach upset, etc.

Current Symptom Review

If you are experiencing any of the symptoms or conditions from the following list, circle all that apply. If no symptoms, check "none"

Constitutional

Weight loss　Night Sweats　❑ None
Weight gain　Fatigue

HEENT:

Vision problems　Double vision　❑ None
Glaucoma　Cataracts
Dry eyes　Itchy eyes
Other eye issues: ____

Hearing problems　Ringing in ears　❑ None
Earaches　Vertigo
Itchy ears
Other ear issues: ____

Nasal congestion　Nasal discharge　❑ None
Nosebleeds　Infection
Other nasal issues: ____

Problems swallowing	Hoarse voice	❑ None
Sore mouth/throat	Bleeding gums	
Dental issues	Dry mouth	

Other oral/throat issues: ____

Endocrine:

Swollen glands	Thyroid problems	❑ None
Diabetes	Menopause	

Other issues: ____

Respiratory:

Cough	Shortness of breath	❑ None
Sputum	Wheezing	
Asthma	COPD	

Other issues: ____

Cardiac:

Heart pain	High blood pressure	❑ None
Heart irregularity	Palpitations	
Swelling in the legs	Difficulty breathing when lying flat	

Other issues: ____

GI:

Constipation	Reflux/heart burn	❑ None
Diarrhea	Nausea/vomiting	
Hepatitis	Cirrhosis	
Decreased liver function		

Other issues: ____

Genitourinary:

Urinary frequency	Burning on urination	❑ None
Blood in urine	Difficulty holding urine	
Vaginal discharge	Yeast infection	Heavy menstrual bleeding
Vaginal dryness	Enlarged prostate	

Other issues: ____

Skin:

Dry skin	Rash	❑ None
Infection	Psoriasis	
Warts	Frequent bruising	

Other issues: ____

Musculoskeletal:

Joint pain	Joint stiffness	❑ None
Joint swelling	Leg weakness	
Chronic pain	Limitation of motion	
Difficulty moving/walking		

Other issues: ____

Neurology:

Headaches	Migraines	❑ None
Seizures	Numbness	
Tremors	Fainting	

Other issues: ____

Heme/lymph:

Bleeding	Blood clots	❑ None
Swollen glands		

Other issues: ____

Immunology:

Allergies	Rash	❑ None
Infections		

Other issues: ____

Psych:

Depression	Anxiety	❑ None
Crying spells	Difficulty sleeping	
Excessive sleeping	Hallucinations	

Other issues: ____

Social:

With whom do you live?____

Are you currently employed? ❑ YES (hours per week _________________) ❑ NO

Position: ____

Do you presently? ❑ smoke ❑ vape ❑ other:

Substance: ❑ nicotine ❑ marijuana ❑ other:

Times per week or cigarettes per week ______________________________

If you smoked or used tobacco in any form previously, how many packs did you smoke per week? ___________ For how many years? _______ When did you quit? ____________________

Do you or have you ever had a Substance Misuse/Abuse Disorder? ❑ YES ❑ NO

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____

Daily activities (describe and explain how often you engage in them):

____

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____

Difficulties in going about activities in daily living (describe): ❑ None

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Hobbies (describe and explain how often you engage in them): ❑ None

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Physical activity, walks, exercise routine:

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Is there anything else you would like to explain about your daily routine?

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____

What is your typical diet?

Breakfast:

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Lunch:

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Dinner:

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Snacks:

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Desert:

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How often do you eat out and what do you typically order when you do?

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Beverages:

Coffee: _______________ cups per day

Soft drinks: ____________ 8 oz servings per day

Water: ________________ 8 oz servings per day

Alcohol: _______________ drinks per day

Other: ____

Medication History:
Please bring all your medications, vitamins, supplements, and other items that you take either regularly or occasionally with you to the visit and please fill out as much of the Medication History Table as possible prior to your visit (see pages 9 and 10).

Immunization History:
When did you last receive the following immunizations?

Influenza	
Tetanus/diphtheria/pertussis	
Herpes Zoster	
Pneumococcal	
Other	
Other	

What are your health goals? Please indicate priority (high, medium, low, long-term, etc)

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Do you have any specific questions about your medications or your health condition?

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What do you hope to get out of your visit?

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Name of medication: *EXAMPLE: Furosemide*		Prescriber: *Dr. Smith (cardiologist)*	Start date: *02/2018*	Problems? *Low potassium*
Dose: *20 mg*	Frequency and timing: *1 tab at 9 am w/ breakfast* *½ tablet at 2 pm*	Indication: *edema*	Stop date: *n/a*	Comments? *Forget to take the 2 pm dose if not at home*
Name of medication:		Prescriber:	Start date:	Problems?
Dose:	Frequency and timing:	Indication:	Stop date:	Comments?
Name of medication:		Prescriber:	Start date:	Problems?
Dose:	Frequency and timing:	Indication:	Stop date:	Comments?
Name of medication:		Prescriber:	Start date:	Problems?
Dose:	Frequency and timing:	Indication:	Stop date:	Comments?
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