COURTYARD CLINIC

Patient Health and History Review

Date: _____

Name: _____ DOB: _____ Age: _____

Gender: M F Other_____ Marital Status: _____

Telephone: Cell: _____ Home: _____ Work: _____

Email: _____

Home address: _____

Provider Information

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

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

Allergies and reactions (include medication and food):

Agent causing allergic reaction: **Medication/ Food/ Environmental**	***Describe the reaction:*** **Allergic:** (rash, hives, anaphylaxis) **Side effects:** (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 Weight gain Fatigue ❑ None

Head Eyes Ears Nose Throat:

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

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

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

Problems swallowing Hoarse voice Sore mouth/throat Bleeding gums
Dental issues Dry mouth
Other oral/throat issues: _____ ❑ None

Endocrine:

Swollen glands Thyroid problems Diabetes Menopause
Other issues: _____ ❑ None

Respiratory:

Cough Shortness of breath Sputum Wheezing Asthma COPD
Other issues: _____ ❑ None

Cardiac:

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

GI:

Constipation Reflux/heartburn Diarrhea Nausea/vomiting Hepatitis
Cirrhosis Decreased liver function
Other issues: _____ ❑ None

Genitourinary:

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

Skin:

Dry skin Rash Infection Psoriasis Warts Frequent bruising
Other issues: _____ ❑ None

Musculoskeletal:

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

Neurology:

Headaches Migraines Seizures Numbness Tremors Fainting
Other issues: _____ ❑ None

Heme/lymph:

Bleeding Blood clots Swollen glands
Other issues: _____ ❑ None

Immunology:

Allergies Rash Infections
Other issues: _____ ❑ None

Psych:

Depression Anxiety Crying spells Difficulty sleeping
Excessive sleeping Hallucinations
Other issues:_____ ❑ None

Social:

With whom do you live?_____

Are you currently employed?

❑ YES (hours per week _____) Position:_____

❑ NO

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

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

Physical activity, walks, exercise routine:

_____

_____

_____

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

_____

_____

What is your typical diet?

Breakfast:

_____

_____

Lunch:

_____

_____

Dinner:

_____

_____

Snacks:

_____

_____

Desert:

_____

_____

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

_____

_____

_____

_____

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 (Shingles)	
Pneumococcal Pneumovax 23	
Pneumococcal Prevnar 13	
Pneumococcal Prevnar 15	
Pneumococcal Prevnar 20	
Hepatitis A	
Hepatitis B	
MMR	
Other	

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

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

What do you hope to get out of your visit?

_____

_____

_____

_____

_____

_____

_____

Medications/Supplements/Vitamins (Please add manufacturer for vitamins) :

Name of medication: *EXAMPLE: Furosemide -IPCA Labs*		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?
Name of medication:		Prescriber:	Start date:	Problems?
Dose:	Frequency and timing:	Indication:	Stop date:	Comments?
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Dose:	Frequency and timing:	Indication:	Stop date:	Comments?