

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. This is very important information. **Please fill out every item.** It is important for you doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Social Security Number (SSN) _____ Date of Visit _____

Full Name _____ Date of Birth _____ Age _____

Pharmacy Preference (include location) _____

Name of Primary Care (Family) Physician _____ Address _____

(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 anything in the environment such as grass, dust, food, etc.?

No Yes If yes, please indicate what you are allergic to. _____

Have you ever had an allergy test? No Yes

(Past Health History) Have you ever been **DIAGNOSED** with any of the following problems?

Cancer (type) _____ No Yes

Are you pregnant? No Yes

Nose and Sinus:

Mental & Emotional:

Nasal Allergies No Yes

Anxiety No Yes

Heart and Blood Vessels:

Depression No Yes

High/Elevated Cholesterol No Yes

Glands, Hormones, and Sugar Control:

High Blood Pressure No Yes

Diabetes No Yes

Lungs and Respiratory:

Thyroid deficiency No Yes

Tuberculosis No Yes

Thyroid excess No Yes

Stomach and Digestive:

Blood & Lymph Node Problems:

Duodenal ulcer No Yes

Anemia No Yes

Hepatitis No Yes

Allergies, Immune & Infectious:

Stomach ulcer No Yes

HIV No Yes

Genitourinary:

Infectious Mononucleosis No Yes

Renal failure No Yes

If you have any other medical problems that we have not covered above, please list those here: _____

(Surgeries and Hospitalizations)

Have you ever had any problems with anesthesia (being numbed or put to sleep)? No Yes

If yes, please list what sort of problems. _____

Have you ever had ear, nose or throat surgery? No Yes

If yes, list any surgeries and when they were done. _____

Have you been hospitalized for a medical problem before? No Yes

If yes, list hospitalizations, the reason for admission and the date. _____

TURN OVER PLEASE!

(Family History)

Specific Anesthesia Problem Mother Father Brother Sister

Cancer:

Lung Cancer Mother Father Brother Sister

Ears:

Hearing Loss before 20 Mother Father Brother Sister

Hearing Loss after 20 Mother Father Brother Sister

Nose and Sinus:

Nasal Allergies Mother Father Brother Sister

Heart and Blood Vessels:

Heart Disease Mother Father Brother Sister

Hypertension Mother Father Brother Sister

Lungs and Respiratory:

Asthma Mother Father Brother Sister

Brain and Nervous:

Stroke Mother Father Brother Sister

Blood & Lymph Node Problems:

Bleeding/clotting problem Mother Father Brother Sister

Other _____ Mother Father Brother Sister

(Social History)

What is or was your occupation? _____ Check here if you're retired.

Have you ever used tobacco in any form? No Yes

Do you consume alcohol? No Yes

If yes, please complete the following:

If yes, please complete the following:

Type of Tobacco	From	To Year	Type of Alcohol	How Much	How Often
Cigarettes per day: _____					
Other: (list type)					

Do you use drugs recreationally? No Yes If yes, please list _____

Are you exposed to second hand smoke? No Yes

(Review of Systems): Mark yes or no and CHECK any of the following you have recently had.

Constitutional Symptoms No Yes

fever, sleeping problems, unintentional weight loss

Musculoskeletal problems No Yes

neck pain

Eye problems No Yes

double vision, itchy eyes

Neurological problems No Yes

headache, numbness, severe facial pain,

seizures, weakness

Ears, Nose, Mouth and Throat problems No Yes

dizziness, ear drainage, hearing loss, ear pain,

ringing, chronic congestion, post-nasal drainage,

hoarseness/change in voice, snoring, sore throat,

ulcers

Problems with Endocrine No Yes

appetite increased, increased fatigue,

feels hot when others do not, feel cold all the time,

neck has enlarged, unwanted weight change

Cardiovascular No Yes

blacking out or fainting,

bluish discoloration of lips or fingernails, chest pain,

irregular heartbeat, leg cramps, swelling of ankles

Problems with Hematological/Lymphatic No Yes

bleeds excessively after injury, bruises easily,

neck masses or lumps

Respiratory problems No Yes

freq non-productive cough, freq productive cough

shortness of breath, wheezing

Allergic, Infectious, Immunologic problems No Yes

food intolerances, hives,

severe reaction to insect bites, frequent sneezing

Gastrointestinal problems No Yes

abdominal pain, diarrhea, heartburn, nausea, vomiting

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