



PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is *very 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 your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Social Security Number (SSN) _____ Appointment Date _____

Full Name _____ Male Female Date of Birth _____

Home Address _____ **E-mail Address _____ Telephone _____

Pharmacy Preference (include location and FAX number) _____

Name of Primary Care (Family) Physician _____ Address _____

Name of Physician or Person who referred you _____

(Current Medications)

Are you taking ANY kind of medication now? (This includes ALL prescription, over-the-counter or herbal medications)

No Yes If yes, please list below *include dosages*. [List any additional medications at the bottom of the last page]

****YOU MUST LIST ALL PAIN MEDICATIONS TAKEN IN THE LAST 6 MONTHS****

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 seafood? No Yes If yes, what reaction do you have? _____

Are you allergic to things that touch your skin, such as iodine, latex, tape? No Yes iodine latex tape

Are you allergic to contrast agents (dye)? No Yes If yes, what reaction do you have? _____

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

Cancer (type) _____ No Yes

Head and Face:

Cluster Headache No Yes

Migraine Headache No Yes

Tension or Stress Headache No Yes

Eyes:

Glaucoma No Yes

Ears:

Chronic Ear Infections No Yes

Nose and Sinus:

Recurrent Sinusitis No Yes

Mouth and Throat:

Sleep Apnea No Yes

Temporomandibular Joint Disease (TMJ) No Yes

No Yes

Heart and Blood Vessels:

Angina No Yes

Atrial Fibrillation No Yes

Blocked Carotid Artery No Yes

Cardiomyopathy No Yes

Stroke No Yes

Congenital Heart Condition No Yes

Congestive Heart Failure No Yes

Coronary Artery Disease No Yes

Deep Vein Thrombosis No Yes

Elevated Blood Cholesterol No Yes

Heart Attack No Yes

Heart Disease No Yes

No Yes

High Blood Pressure No Yes

Irregular Heart Beat No Yes

Peripheral Vascular Disease No Yes

Transient Ischemic Attack No Yes

Lungs and Respiratory:

Asthma No Yes

Chronic Bronchitis No Yes

Emphysema No Yes

Pneumonia No Yes

Stomach and Digestive:

Cirrhosis No Yes

Duodenal Ulcer No Yes

Gastroesophageal Reflux No Yes

Hepatitis No Yes
Pancreatitis No Yes

Stomach Ulcer No Yes
Date of Last Menstrual Period: _____

Are you pregnant? No Yes
General Prostate Problems No Yes
Prostate Enlargement No Yes
Recurring Prostatitis No Yes

Kidneys and Urinary Tract:
General Kidney Disease No Yes
Renal Failure No Yes
Renal Insufficiency No Yes
General Urination Problems No Yes

Bones, Joints and Muscles:
Ankylosing Spondylitis No Yes
Arthritis No Yes
Benign Bone Tumor No Yes
Cut Nerve No Yes
Disk Disorder In Back No Yes
Disk Disorder In Neck No Yes
Gout No Yes
Osteoporosis No Yes

(Surgeries and Hospitalizations)

Have you had problems with anesthesia (being partially or totally put to sleep)?
 high fever trouble with intubation (placement of breathing tube)

Have you had ANY surgery? No Yes
If yes, list types and when they were done. _____

(Serious Injury)

Head Injury:
with unconsciousness No Yes
Neck injury:
Whiplash No Yes

Back Injury:
ruptured C5-6 disc No Yes
ruptured C6-7 disc No Yes
ruptured L3-4 disc No Yes
ruptured L4-5 disc No Yes
ruptured L5-S1 disc No Yes

Bone Injury:
fractured cervical spine No Yes
fractured lumbar spine No Yes
fractured thoracic spine No Yes
Joint Injury:
List _____

(Family History)

Family history not known:
 Patient is adopted There are no living relatives
Specific Anesthesia Problem
High fever during surgery Father Mother Brother Sister
Head and Face:
Migraine Headaches Father Mother Brother Sister

Mental and Emotional:
Alcoholism Father Mother Brother Sister
Substance Abuse Father Mother Brother Sister
Blood & Lymph node problems:
Bleeding/clotting problem Father Mother Brother Sister
Other _____ Father Mother Brother Sister

(Social History)

What is or was your occupation? _____ Check here if you are retired.
Marital status: single, married, divorced, widowed, legally separated, co-habiting

Have you used tobacco in any form? No Yes
If yes, please complete the following:

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

Do you consume alcohol? No Yes
If yes, mark the most accurate description of your drinking habits.
 Less than 12 alcoholic beverages in past year
 1-13 alcoholic beverages per month
 4-14 alcoholic beverages per week
 More than 2 alcoholic beverages per day
 Intermittent consumption, and 5 or more drinks at a single session

Do you have a history of alcoholism: No Yes If yes, not in the process of recovery a recovering alcoholic.

Do you drugs recreationally? No Yes If yes, please list _____
 Have you been addicted or dependent on drugs? No Yes If yes, please list _____
 Have you had treatment for drug dependence or addiction No Yes
 Have you ever been convicted of a felony? No Yes

If YES, please explain _____

Have you served time in a jail/prison? No Yes If YES, when? _____

Hand dominance: right, left, ambidextrous

Home living situation and relationships: Lives alone, with spouse, with children, with mother, with father, with a legal guardian, with foster parent(s), in an assisted living residence, in a nursing home, other _____

Personal handicaps, disabilities, and assistive devices: none, legally blind, neurologic disorder, uses a cane, uses a wheelchair,

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

Constitutional Symptoms No Yes
 (fatigue, fever, sleeping problems, unintentional weight loss)

Eye problems No Yes
 (blurred vision, double vision, loss of vision)

Ear problems No Yes
 (dizziness, hearing loss, ear pain, ringing)

Mouth & Throat problems No Yes
 (hoarseness /change in voice, snoring, teeth in poor condition)

Cardiovascular No Yes
 (chest pain heat murmur, irregular heartbeat, lightheadedness or near fainting on standing up)

Respiratory problems No Yes
 (shortness of breath, sleep disturbance due to breathing)

Gastrointestinal problems No Yes
 (abdominal pain, constipation, diarrhea, heartburn, nausea, vomiting)

Gender and Urinary related problems No Yes
 genital pain, scrotal pain, testicular pain, flank pain, pain or burning with urination

Musculoskeletal problems No Yes
 (muscle cramping, loss of muscle strength, back pain, neck pain, joint pain, stiffness in joints, joint swelling)

Neurological problems No Yes
 (change in alertness, difficulty speaking, difficulty thinking, difficulty walking, difficulty with balance, excessive daytime sleepiness, headache, loss of bladder control, loss of bowel control, numbness, severe facial pain, seizures, sensation of room spinning, weakness)

Mental and Emotional problems No Yes
 (suicidal plans, suicidal thoughts)

Problems with Endocrine No Yes
 (excessive sweating)

Problems with Hematologic/Lymphatic No Yes
 (bone pain, persistent swelling in the limbs)

Allergic, Infectious, Immunologic Problems No Yes
 (low blood pressure, multiple aching joints with fever, rash after contact with a specific substance, recurrent swelling of the face, lips and/or tongue)

Briefly, what is the main reason you are seeing the doctor today?

****Please be certain to include your e-mail address, if you have one. We use e-mail as the preferred route to communicate with our patients.**

Thank You for Your Cooperation