PATIENT HEALTH HISTORY FORM

DATE: ____________________

NAME: ______________________________ **DOB:** ____________

PHONE NUMBER WHERE WE CAN REACH YOU DURING THE DAY: ____________________

PHONE NUMBER WHERE WE CAN LEAVE A DETAILED MESSAGE: ____________________

MEDICATIONS: (Please list all medications, dose and frequency)

1. ____________________ 2. ____________________
3. ____________________ 4. ____________________
5. ____________________ 6. ____________________

LIST MEDICATION ALLERGIES? ____________________ ☐ None

OTHER ALLERGIES? FOOD __________ LATEX __________ OTHER __________

HEIGHT: _______ **WEIGHT:** ________ **BP:** _________ **TEMP:** ______ **PULSE:** _______

WHAT ARE YOU BEING SEEN FOR TODAY? ____________________

____

MEDICAL HISTORY : ☐ HIGH BLOOD PRESSSURE ☐ CANCER ☐ HEART DISEASE ☐ DIABETES ☐ BLOOD CLOTS/BLEEDING PROBLEMS ☐ SLEEP APNEA ☐ OTHER __________

HISTORY OF ANY SURGERY:

____

____

HAVE YOU OR ANY RELATIVES HAD A PROBLEM WITH ANESTHESIA? ☐ YES ☐ NO__________

HAVE YOU EVER HAD AN EKG? ☐ YES ☐ NO WHY__________

WHEN/WHERE __________

SOCIAL HISTORY:

YOU LIVE	☐ ALONE ☐ W/SPOUSE ☐ W/FAMILY ☐ APT/CONDO ☐ HOUSE ☐ ASSISTED LIVING		
PREGNANT	☐ YES	☐ NO	LAST MENSTRUAL PERIOD: __________
CAFFEINE	☐ YES	☐ NO	HOW MUCH: __________
TOBACCO USE	☐ YES	☐ NO	HOW MUCH: __________
ALCOHOL/DRUG USE	☐ YES	☐ NO	TYPE/FREQUENCY: __________
DO YOU EXERCISE?	☐ YES	☐ NO	FREQUENCY: __________

HOW FAR CAN YOU WALK COMFORTABLY ____ BLOCKS ____ MILES

CAN YOU CLIMB STAIRS? ☐ NO ☐ YES ☐ WITHOUT ASSISTANCE ☐ WITH ASSISTANCE

MORE ON BACK ↓

REVIEW OF SYSTEMS

HEENT (Head, Eyes, Ears, Nose, Throat)

- ☐ Yes ☐ No Headache
- ☐ Yes ☐ No Hard of hearing/Hearing aid
- ☐ Yes ☐ No Dentures/Caps/Loose teeth
- ☐ Yes ☐ No Jaw/Neck, range of motion
- ☐ Yes ☐ No Vocal cord problems
- ☐ Yes ☐ No Eye trauma
- ☐ Yes ☐ No Double vision
- ☐ Yes ☐ No Contact Lenses/Glasses

NEUROLOGIC

- ☐ Yes ☐ No Numbness
- ☐ Yes ☐ No Balance problems
- ☐ Yes ☐ No Seizures
- ☐ Yes ☐ No Weakness
- ☐ Yes ☐ No Memory loss
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Psychiatric problems

RESPIRATORY

- ☐ Yes ☐ No Recent cold/cough
- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Shortness of breath/Asthma, COPD

SKIN

- ☐ Yes ☐ No Lesions
- ☐ Yes ☐ No Rash
- ☐ Yes ☐ No Scars
- ☐ Yes ☐ No Masses
- ☐ Yes ☐ No Eczema
- ☐ Yes ☐ No MRSA

CARDIOVASCULAR

- ☐ Yes ☐ No Murmur/Irregular rhythm
- ☐ Yes ☐ No Pacemaker/AICD
- ☐ Yes ☐ No Congestive failure
- ☐ Yes ☐ No Swelling of ankles

URINARY

- ☐ Yes ☐ No Renal failure
- ☐ Yes ☐ No Hesitancy
- ☐ Yes ☐ No Pain
- ☐ Yes ☐ No Incontinence
- ☐ Yes ☐ No Kidney stones
- ☐ Yes ☐ No Bladder infections

GASTROINTESTINAL

- ☐ Yes ☐ No Reflux Heartburn
- ☐ Yes ☐ No Ulcers
- ☐ Yes ☐ No Liver problems/Hepatitis/Jaundice
- ☐ Yes ☐ No Nausea/vomiting
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Communicable diseases
- ☐ Yes ☐ No Constipation/Pain
- ☐ Yes ☐ No Blood in stool

METABOLIC

- ☐ Yes ☐ No Weight gain
- ☐ Yes ☐ No Thyroid problem
- ☐ Yes ☐ No Nutritional problem
- ☐ Yes ☐ No Weight loss
- ☐ Yes ☐ No Fatigue

MUSCULOSKELETAL

- ☐ Yes ☐ No Arthritis
- ☐ Yes ☐ No Paralysis
- ☐ Yes ☐ No Physical limitations
- ☐ Yes ☐ No Artificial limbs

FAMILY HISTORY

- ☐ Yes ☐ No Blood Clots/Bleeding Disorder
- ☐ Yes ☐ No Cancer
- ☐ Yes ☐ No Diabetes
- ☐ Yes Other ______________________
- ☐ Yes ☐ No Heart Disease
- ☐ Yes ☐ No High Blood Pressure/Hypertension
- ☐ Yes ☐ No Sleep Apnea
- ☐ Yes ☐ No MRSA

PRINT PATIENT NAME: ______________________ D.O.B. ______________________

PATIENT SIGNATURE: ______________ DATE: ________ DR. SIGNATURE: ______________ DATE: ________

REVIEW BY PATIENT: __________ (Initial Date) REVIEWED BY PATIENT: __________ (Initial Date) REVIEWED BY PATIENT: __________ (Initial Date)

REVIEWED BY DOCTOR: __________ (Initial Date) REVIEWED BY DOCTOR: __________ (Initial Date) REVIEWED BY DOCTOR: __________ (Initial Date)

ASC REVIEWED BY: ______________________ DATE: ______________________