

# 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: \_\_\_\_\_

MEDICAL HISTORY :  HIGH BLOOD PRESSURE  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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hard of hearing/Hearing aid	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dentures/Caps/Loose teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw/Neck, range of motion	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vocal cord problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Double vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Lenses/Glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No
NEUROLOGIC	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Balance problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Memory loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

RESPIRATORY	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent cold/cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath/Asthma, COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No
SKIN	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scars	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Masses	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No

CARDIOVASCULAR	<input type="checkbox"/> Yes <input type="checkbox"/> No	Murmur/irregular rhythm	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker/AICD	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congestive failure	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
URINARY	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal failure	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hesitancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder infections	<input type="checkbox"/> Yes <input type="checkbox"/> No

GASTROINTESTINAL	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reflux Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver problems/Hepatitis/Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea/vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Communicable diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation/Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in stool	<input type="checkbox"/> Yes <input type="checkbox"/> No
METABOLIC	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight gain	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nutritional problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No

MUSCULOSKELETAL	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical limitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HISTORY	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Clots/Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure/Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRINT PATIENT NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DR. SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEWED BY PATIENT: \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_

REVIEWED BY DOCTOR: \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_

REVIEWED BY PATIENT: \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_

REVIEWED BY DOCTOR: \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_

ASC REVIEWED BY: \_\_\_\_\_ DATE: \_\_\_\_\_