PATIENT HEALTH HISTORY FORM

DATE: ____________________

NAME: ____ **DOB:** ______________

PHONE NUMBER WHERE WE CAN REACH YOU AND/OR LEAVE A DETAILED MESSAGE: ______________

PRIMARY CARE MD: ______________________ **PHONE:** ______________

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? ______________________

DO YOU HAVE ANY CONCERNS YOU WOULD LIKE TO DISCUSS W/THE MEDICAL STAFF? ______________

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

HISTORY OF ANY SURGERY/HOSPITALIZATIONS:

____

____

HAVE YOU EVER HAD A BLOOD TRANFUSION? ☐ YES ☐ NO IF SO WHEN? ______________

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: ______________

CAN YOU CLIMB 2 FLIGHTS OF STAIRS WITHOUT SHORTNESS OF BREATH? ☐ YES ☐ NO
☐ 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 / TB

SKIN
- ☐ Yes ☐ No Lesions
- ☐ Yes ☐ No Rash
- ☐ Yes ☐ No Scars
- ☐ Yes ☐ No Masses
- ☐ Yes ☐ No Eczema
- ☐ Yes ☐ No MRSA (Active)
- ☐ Yes ☐ No HX of 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 / Gerd
- ☐ Yes ☐ No Liver problems / Hepatitis / Jaundice
- ☐ Yes ☐ No Nausea / Vomiting / Motion Sickness
- ☐ 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

FAILED CONSERVATIVE MANAGEMENT
- Have you tried antiinflammatory? ☐ Yes ☐ No ______________
- Have you tried PT? ☐ Yes ☐ No ______________
- Have you had injections? ☐ Yes ☐ No ______________
- Have you tried weight loss? ☐ Yes ☐ No
- Have you tried braces? ☐ Yes ☐ No
- Have you tried a cane? ☐ Yes ☐ No

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: ________

REVIEWED 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: ______________