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HEALTH HISTORY FORM

Patient Information	
Name:	**Home Phone Number:**
Address:	**Cell Phone Number:**

Primary Care Provider Information
Name:
Address:
Phone Number:
Fax Number:

Specialty Care Provider Information				
Provider Name/Specialty	**Last Visit Date (Approximate)**	**Practice Name/Address**	**Phone Number**	**Fax Number**

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Allergies	
Food/Medication/Environmental Allergy	**Reaction (e.g. rash, hives, facial swelling)**

Medications (inhalers, eye/ear drops, supplements) *Alternatively, request a list of your medications from your pharmacy and bring it to the visit.*				
Medication Name	**Frequency**	**Dose**	**Route (oral, inhaled, injection)**	**Condition for which Medication is Prescribed**

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Past Medical History (Please check all that apply)		
☐ **No past medical history**		
Eyes/Ears ☐ Glaucoma ☐ Problems with vision ☐ Problems with hearing ☐ Vertigo (dizziness)	**Neurological** ☐ Stroke ☐ Paralysis ☐ Quadriplegia ☐ Paraplegia ☐ Hemiplegia ☐ Seizure Disorder (not on meds) ☐ Epilepsy (currently on meds) ☐ Alzheimer's ☐ Syncope or unexplained loss of consciousness ☐ Dementia ☐ Schizophrenia ☐ Depression ☐ Cerebral Palsy ☐ Multiple Sclerosis ☐ Parkinson's	**Heart** ☐ Heart Disease ☐ Irregular Heart Rhythm ☐ Atrial Fibrillation ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Failure ☐ Angina (chest pain related to heart)
Lungs ☐ COPD (Chronic Obstructive Pulmonary Disease) ☐ Oxygen Therapy ☐ Emphysema ☐ Obstructive Sleep Apnea ☐ Home BiPap/CPAP ☐ Asthma (493.9) ☐ Chronic Bronchitis (491.9) ☐ Cystic Fibrosis (277.00) ☐ Currently with Tracheostomy(v44.0)	**Endocrine** ☐ Diabetes ☐ Diabetes Type II ☐ Diabetes Type I ☐ Pre-Diabetes ☐ Hyperparathyroidism ☐ Hypothyroidism ☐ Hyperthyroidism	**Cancer** ☐ Lung Cancer ☐ Liver Cancer ☐ Colon Cancer ☐ Skin Cancer ☐ Lymphoma/Bone Marrow Cancer ☐ Leukemia ☐ Hodgkin's ☐ Prostate Cancer ☐ Breast Cancer ☐ Ovarian Cancer ☐ Uterine Cancer ☐ Other Cancer
Liver/Pancreas/Kidney ☐ Liver Disease/Disorder ☐ Hepatitis ☐ Cirrhosis ☐ Chronic Pancreatitis ☐ Celiac Disease (gluten sensitivity) ☐ Kidney Disease or Renal Failure ☐ Receiving Dialysis	**Gastrointestinal** ☐ Colon Polyps ☐ Inflammatory Bowel Disease ☐ Ulcerative Colitis ☐ Crohn's Disease ☐ Peptic Ulcer Disease ☐ Artificial opening for feeding or elimination ☐ Abnormal loss of weight	**Skin/Circulatory** ☐ Skin Sore or Ulcer ☐ Decubitis Ulcer (pressure ulcer) ☐ Peripheral Vascular Disease ☐ Non-healing wounds or discoloration of leg

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Blood & Bone ☐ Blood Disorder ☐ Hemophilia or other clotting disorder ☐ Multiple Myeloma ☐ HIV Positive asymptomatic ☐ HIV Positive symptomatic ☐ Osteoporosis or low bone mass - Receiving osteoporosis drug therapy? ☐ Yes ☐ No ☐ Vertebral Fracture(s) ☐ Hip Fracture(s) ☐ Receiving oral steroid medications (e.g. Prednisone) for more than 3 months ☐ SLE (Lupus) ☐ Systemic Sclerosis ☐ Sjogren's ☐ Rheumatoid Arthritis ☐ Osteomyelitis (currently being treated) ☐ Acute Osteomyelitis ☐ Chronic Osteomyelitis ☐ Bone Infection (currently being treated) ☐ Sickle Cell Disease	**Gender Specific:** **Male** ☐ Benign prostatic hypertrophy **Female** ☐ Taken birth control for 5 or more years ☐ Delivered a baby weighing more than 9 pounds ☐ Gestational Diabetes ☐ Exposed to DES (diethylstilbestrol) prior to birth ☐ Fewer than 3 negative Pap tests ☐ Early onset of sexual activity (under 16 years of age) ☐ Five or more sexual partners within a lifetime ☐ History of a sexually transmitted disease (including HPV and/or Human Immunodeficiency Virus [HIV])
Additional Past Medical History:	

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Vaccination History				
Vaccine	**Received (✓)**			**Date(s) (if known) Month/Year**
	Yes	**No**	**Not Sure**	
Pneumonia				
Influenza (Flu shot)				
Tdap (Tetanus, Diphtheria, Pertuss				
Td (Tetanus)				
Zostavax (Shingles)				
Hepatitis B (3 shot series)				

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Health Screening History								
		Received Screening (✓)			Date (if known) Month/Year	Results (✓) (if known)		
Screening Test	**Type of Screening**	**Yes**	**No**	**Not Sure**		**Normal**	**Abnormal**	**If "Abnormal", briefly describe:**
HIV	HIV/AIDS							
Fasting Blood Glucose or Glucose Tolerance Test	Diabetes							
Fasting Lipid Profile	Cholesterol							
Prostate Specific Antigen (PSA)	Prostate Cancer							
Digital Rectal Exam (DRE)	Prostate Cancer							
Colonoscopy	Colon Cancer							
Fecal Occult Blood	Colon Cancer							
Flexible Sigmoidoscopy	Colon Cancer							
Barium Enema	Colon Cancer							
Mammogram	Breast Cancer							
Pap/Pelvic	Cervical Cancer							
Bone Mass Density	Osteoporosis							
Glaucoma	Vision							
Dilated Retinal Exam	Vision							
Dental Exam	Dental							
Spirometry Test	Pulmonary							
If diagnosed with diabetes: Monofilament Test	Diabetic Comprehensive Foot Exam							

Past Surgical/Interventional History (Please check all that apply)		
☐ Cataract removal	☐ Heart surgery	**Joint replacement surgery**
☐ Cochlear implant	☐ Organ transplant	☐ Shoulder
☐ Back surgery	☐ Splenectomy	☐ Hip
☐ Gall bladder removal	☐ Other _____	☐ Knee

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Hospitalizations, Major Illnesses or Injuries		
Type	**Date (Month/Year)**	**Briefly describe the major illness, injury and/or reason for hospitalization**
☐ Hospitalization ☐ Major Illness ☐ Injury		
☐ Hospitalization ☐ Major Illness ☐ Injury		
☐ Hospitalization ☐ Major Illness ☐ Injury		
☐ Hospitalization ☐ Major Illness ☐ Injury		
☐ Hospitalization ☐ Major Illness ☐ Injury		
☐ Hospitalization ☐ Major Illness ☐ Injury		

End-of-Life Planning

End-of-Life Planning consists of a legal document (e.g. Living Will, Advanced Directive) that explains your wishes should you become incapacitated and unable to express your wishes regarding life-saving/sustaining medical interventions.

Have you established a Living Will or Advanced Directive? ☐ Yes ☐ No

If you answered "No", would you like more information regarding obtaining end-of-life planning? ☐ Yes ☐ No

If you answered "Yes", do you feel that your Primary Care Physician is willing to follow your wishes as expressed in the Living Will or Advanced Directive? ☐ Yes ☐ No

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Review of Systems - Recent Medical History (Genitourinary) (Please check all that apply)	
The questions in this section are asked to determine whether a chaperone will be needed for your visit. **In the past six to eight months, have you experienced any of the following?** ☐ **No recent medical history (genitourinary)**	
☐ Lump or bump in groin area ☐ Pain or aching sensation in groin area ☐ Discomfort or pain in groin area when lifting heavy objects (≥10 lbs)	☐ Change in breast size or shape ☐ Nipple discharge ☐ New or change in breast lump(s) or masses ☐ Breast pain
Other health problems or concerns: _____ _____ _____	

Home Safety Assessment: How well does your home meet your needs?		
Place a "√" in the box to indicate "Yes" or "No" to each of the following questions:		
Steps/Stairways or Walkways	**Yes**	**No**
Are they in good shape?		
Do they have a smooth, safe surface?		
Are there handrails on both sides of the stairway?		
Do you have light switches at the top and bottom of the stairs?		
Is there grasping space for both knuckles and fingers on the railings?		
Are the stair treads deep enough for your whole foot?		
Would there be room enough to install a ramp in any of these areas if it became necessary?		
Floor Surfaces	**Yes**	**No**
Are floor surfaces safe?		
Are they nonslip?		
Are throw rugs or doormats placed so that they will not slip underfoot?		
Is carpeting firmly placed and free from tears?		
If there are floor level changes, are they obvious and/or well-marked?		
Are electric, telephone, or extension cords placed so that you do not have to step over them?		
Driveway and Garage	**Yes**	**No**

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Is there always space to park?		
Is it convenient to the entrance?		
Does the garage door open automatically?		
Window and Doors	**Yes**	**No**
Are windows and doors easy to operate?		
Do doorways accommodate a walker or wheelchair?		
Can you walk through the doorways easily?		
Is there space to maneuver while opening and closing doors?		
Does the front door have a view panel or peephole at the right height?		
Appliances/Kitchen/Bath	**Yes**	**No**
Is the room arranged safely and conveniently?		
Do the oven and fridge open easily?		
Are stove controls clearly marked and easy to use?		
Is the counter the right height and depth?		
Can you work sitting down?		
Are cabinet doorknobs easy to use?		
Are faucets easy to use?		
Do you have a hand-held shower head?		
Are the items you use often within reach on shelves?		
Do you have a step stool with handles?		
Can you easily get in and out of the tub or shower?		
Do you have a bath or shower seat?		
Are there grab bars where needed?		
Is the hot water heater regulated to prevent scalding or burning?		
Lighting/Ventilation	**Yes**	**No**
Are there enough lights, and are they bright enough?		
Do you have night lights where needed?		
Is area well ventilated?		
Electrical Outlets/Switches/Alarms	**Yes**	**No**
Can you easily turn switches on and off?		
Are outlets properly grounded to prevent a shock?		
Are extension cords in good shape?		
Do you have smoke detectors in all key areas?		
Do you have an alarm system?		
Is the telephone readily available for emergencies?		
Does the telephone have a volume control?		
Can you hear the doorbell ring all throughout the house?		

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