**Health History Page 1**

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**First Name M.I. Last Name**

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**Occupation Date of Birth Primary Care Provider**

**Reason for Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Check if the patient has any problems with the following areas:**

**GENERAL:** fatigue weight gain weight loss fevers chills night sweats

**HEENT:** change in vision change in hearing ear pain throat pain hoarseness

headaches sinus disease nasal congestion dizziness

**SKIN:** rashes lesions skin cancer pigmentary changes

**CARDIOVASCULAR:** shortness of breath shortness of breath with activity chest pain

**RESPIRATORY:** cough emphysema shortness of breath

**GI:** abdominal pain diarrhea constipation nausea emesis reflux

**NEUROLOGICAL:** loss of memory seizures weakness numbness

**PSYCHIATRIC:** psychosis/hallucinations depression anxiety bipolar disorder

**ENDOCRINE:** thyroid disease elevated calcium adrenal tumors

**GENITO-URINARY:** kidney stone prostate enlargement painful urination infections

**HEMATOLOGIC/IMMUNOLOGIC:** Immunodeficiency bleeding disorders history of blood transfusions

**Please list all ALLERGIES to medications: Please list all REGULAR MEDICINES and doses:**

**(or provide a list) (or provide a list)**

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**First Name M.I. Last Name**

**MEDICAL HISTORY**

**Circle** if the patient has or had the following: (put year diagnosed next to it)

Heart attack­­­ \_\_\_\_\_\_\_\_\_\_ Cancer \_\_\_\_\_\_\_\_\_\_\_

High blood pressure \_\_\_\_\_\_\_\_\_\_ Pneumonia \_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_ Emphysema \_\_\_\_\_\_\_\_\_\_\_

Mitral valve prolapse \_\_\_\_\_\_\_\_\_\_ Bronchitis \_\_\_\_\_\_\_\_\_\_\_

Stroke(s) / TIA’s \_\_\_\_\_\_\_\_\_\_ COPD \_\_\_\_\_\_\_\_\_\_\_

TB \_\_\_\_\_\_\_\_\_\_ AIDS \_\_\_\_\_\_\_\_\_\_\_

Hepatitis \_\_\_\_\_\_\_\_\_\_ HIV + \_\_\_\_\_\_\_\_\_\_\_

Colitis \_\_\_\_\_\_\_\_\_\_ Heart Conditions \_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY**

**Circle** if the patient has had any of the following operations: (enter the year the surgery was done in the space provided)

Hysterectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adenoidectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Back or Disc operation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tonsillectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid or Neck \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Breast Biopsy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appendectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hernia Repair \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gall Bladder Removal (Cholecystectomy) \_\_\_\_\_\_\_\_\_\_ Ear tubes - If so, number of times?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any **other operations** and year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has the patient had any **problems with anesthetics** used during surgery? YES NO

If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HABITS**

Does anyone in the patient’s house smoke? Yes No

Does the patient use tobacco? Yes No Type of tobacco used? Chew\_\_\_\_\_\_\_ Smoke\_\_\_\_\_\_\_\_Cigarettes\_\_\_\_\_ Cigars\_\_\_\_\_\_\_

How many cans, packs or cigars per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the patient tobacco dependent? Yes No

Quit?:\_\_\_\_\_\_\_\_\_\_\_\_ When?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient drink alcohol? Yes No Type of alcohol used? Liquor\_\_\_\_ Beer\_\_\_\_\_ Wine\_\_\_\_\_

How many drinks per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the patient alcohol dependent? Yes No

Has the patient had a blood transfusion? Yes No If so, what year?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient up to date on immunizations? Yes No Does the patient have any pets in the house? Yes No

If yes what type of pet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY** If family history is unknown please check here\_\_\_\_\_\_\_\_\_\_\_.

**Circle** the patient’s **mother (M), father (F), brother (B), or sister(S)** if they have had any of the following illnesses or problems. If circled please indicate if they are still alive or deceased by marking A=Alive, D=Deceased next to the circled family member.

Heart Attacks M F B S

Diabetes M F B S

High Blood Pressure M F B S

Tuberculosis M F B S

Cancer M F B S Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Disorder M F B S