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: _____

LIST MEDICATIONS (Names only):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

LIST MEDICATION ALLERGIES: _____ ☐

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 _____

PLEASE LIST ANY PREVIOUS 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

SEE NEXT PAGE ↓

REVIEW OF SYSTEMS

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

Y/N Neck problems
Y/N Thoracic outlet symptoms
Y/N Bunions
Y/N Herna

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: _____