MY HEALTH HISTORY

Submitted by:

Date:

Chief Complaint:

VITALS	Height:
Temperature:	Weight:
Blood Pressure:	Pulse:
Respiratory:	Pain:

NAME:				To Receive Appointment Information By Email, Please Include Your Email Address:
DOB:	**AGE:**	**RELIGION:**		**EMAIL:**
TELEPHONE:	**Home:**	**Cell:**	**Work:**	We Will Provide Your Health Information To Your Primary Care Physician (PCP).
				PRIMARY CARE PHYSICIAN:

Emergency Contact:	Emergency Number:	To Release Your Health Information To Anyone Other Than Your PCP, Please Ask For A Records Release. If You Wish To Share Your Medical Information With Another Person, Please List Their Name, Telephone Number And Relationship:
Do You Have A Medical Power Of Attorney And/Or A Living Will? Yes ☐ No ☐	Do You Have A Copy? Yes ☐ No ☐	
MARITAL STATUS: ☐Married ☐Single ☐Separated ☐Widowed ☐Divorced ☐Domestic Partners		**NAME:** **RELATIONSHIP:** **TELEPHONE:**

MY PAST MEDICAL PROBLEMS:

Arthritis/Gout	Yes ☐ No ☐	Date Of Last DEXA Scan	
Asthma/Bronchitis/Allergies	Yes ☐ No ☐	Date Of Last Colonoscopy	
Bronchitis	Yes ☐ No ☐	Date Of Hemoccult Stool Test	
Cancer	Yes ☐ No ☐		
Crohn's Disease	Yes ☐ No ☐	Date Of Last Pap Smear:	
Diabetes	Yes ☐ No ☐	Age At First Period:	
Emotional Disorders	Yes ☐ No ☐	Number Of Pregnancies:	
Emphysema/COPD/Pneumonia	Yes ☐ No ☐	Numbers Of Births:	
Gallbladder	Yes ☐ No ☐	Age When First Child Was Born:	
Heart Attack	Yes ☐ No ☐	Date Of Last Menstrual Period	
Heart Disease	Yes ☐ No ☐	Length Of Menstrual Cycles In Days:	
Heart Valve Disease	Yes ☐ No ☐	Age At Menopause (Natural/Surgical):	
Hepatitis/Cirrhosis	Yes ☐ No ☐	Do You Use Hormones:	Yes ☐ No ☐
High Blood Pressure	Yes ☐ No ☐	If Yes, How Long?	
High Cholesterol	Yes ☐ No ☐	Date Of Last Mammogram	
Kidney/Bladder Disease	Yes ☐ No ☐	Breast Lump?	Yes ☐ No ☐
Lupus	Yes ☐ No ☐	If Yes, Date/Duration	Right ☐ Left ☐
Osteoporosis	Yes ☐ No ☐	Nipple Discharge?	Yes ☐ No ☐
Reflux Disease	Yes ☐ No ☐	If Yes, Date/Duration	Right ☐ Left ☐
Scleroderma	Yes ☐ No ☐	Breast Skin Changes?	Yes ☐ No ☐
Seizures/Epilepsy	Yes ☐ No ☐	If Yes, Date/Duration	Right ☐ Left ☐
Skin Problems	Yes ☐ No ☐	Breast Pain?	Yes ☐ No ☐
STD/AIDS/HIV	Yes ☐ No ☐	If Yes, Date/Duration	Right ☐ Left ☐
Stroke	Yes ☐ No ☐		
Thyroid	Yes ☐ No ☐	**MY FAMILY HISTORY - CANCER**	
Tuberculosis	Yes ☐ No ☐	Please List All Immediate Family Members With A History Of Cancer, Type Of Cancer And What Age They Were Diagnosed If Known:	
Ulcerative Colitis	Yes ☐ No ☐		
Ulcers/Acid Reflux	Yes ☐ No ☐	1.	
Unusual Bleeding/Anemia/Clots	Yes ☐ No ☐	2.	
		3.	
MY PREVIOUS SURGERIES/OPERATIONS AND DATES		4.	
1.	Date:		
2.	Date:	**NOTES:**	
3.	Date:		
4.	Date:		

EXPOSURE TO HAZARDOUS MATERIALS

(Please Check All That Apply)

Asbestos	Yes ☐	No ☐	Coal	Yes ☐	No ☐
Benzene	Yes ☐	No ☐	Lead	Yes ☐	No ☐

MY AVERAGE DAILY ACTIVITY LEVEL

☐ Sedentary	(Reading, Watching TV)
☐ Light Activity	(Household Chores)
☐ Moderate Activity	(Brisk Walking/Dancing)
☐ Vigorous Activity	(Race Walking/Jogging)

MY SUPPORT SYSTEM

- ☐ Live With Spouse Or Significant Other
- ☐ Live In Nursing Home
- ☐ Incarcerated
- ☐ No Support System Exists
- ☐ Live Alone
- ☐ Live In Own House
- ☐ Homeless
- ☐ Supportive Family/Friends Willing To Assist
- ☐ Adequate Transportation Available

MY NUTRITION

☐ Regular Meals	☐ Diabetic Diet
☐ Vegetarian Diet	☐ Nutritional Supplements

MY ALLERGIES

Latex Allergy?	Yes ☐ No ☐
Iodine/IV Contrast Allergy?	Yes ☐ No ☐
All Other Known Allergies?	

PERTINENT HISTORY

Previous Radiation Therapy	Yes ☐ No ☐
Previous Chemotherapy	Yes ☐ No ☐
Do You Have a Pacemaker?	Yes ☐ No ☐
Is There A Possibility You Might Be Pregnant?	Yes ☐ No ☐

SOCIAL HISTORY (CHECK ALL THAT APPLY)

Do You Smoke?	Yes ☐ No ☐
If Yes, How Many Years?	
How Many Packs Per Day?	Yes ☐ No ☐
If You Quit Smoking, Date You Quit:	
Do You Drink Alcohol?	Yes ☐ No ☐
If Yes, Amount Of Alcohol Per Day?	
Have You Used Illegal Drugs?	Yes ☐ No ☐
If Yes, Type Of Drug(S)?	
When?	

NOTES:

MY MEDICATION LIST

Please List All Information For Each Medication.

Drug/Dose:	How Often/Why?	Drug/Dose:	How Often/Why?
Drug/Dose:	How Often/Why?	Drug/Dose:	How Often/Why?
Drug/Dose:	How Often/Why?	Drug/Dose:	How Often/Why?
Drug/Dose:	How Often/Why?	Drug/Dose:	How Often/Why?
Drug/Dose:	How Often/Why?	Drug/Dose:	How Often/Why?
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Drug/Dose:	How Often/Why?	Drug/Dose:	How Often/Why?
Drug/Dose:	How Often/Why?	Drug/Dose:	How Often/Why?
Drug/Dose:	How Often/Why?	Drug/Dose:	How Often/Why?

PLEASE COMPLETE					
GENERAL/CONSTITUTIONAL			**MUSCULOSKELTAL**		
Weakness/Fatigue	Yes ☐	No ☐	Muscle Aches	Yes ☐	No ☐
Weight Loss	Yes ☐	No ☐	Bone Pain	Yes ☐	No ☐
Fevers/Chills	Yes ☐	No ☐	Joint Pain	Yes ☐	No ☐
Night Sweats	Yes ☐	No ☐	Joint Swelling/Redness	Yes ☐	No ☐
			Decreased Range Of Motion	Yes ☐	No ☐
EYES			Osteoporosis	Yes ☐	No ☐
Blurred Vision	Yes ☐	No ☐			
Double Vision	Yes ☐	No ☐	**NEUROLOGICAL**		
Redness	Yes ☐	No ☐	Headaches	Yes ☐	No ☐
Pain	Yes ☐	No ☐	Numbness	Yes ☐	No ☐
Excessive Watering	Yes ☐	No ☐	Tingling	Yes ☐	No ☐
			Focal Weakness	Yes ☐	No ☐
EAR, NOSE AND THROAT			Seizures	Yes ☐	No ☐
Difficulty Swallowing	Yes ☐	No ☐	Sensory Problems	Yes ☐	No ☐
Change In Voice	Yes ☐	No ☐	Normal Stride	Yes ☐	No ☐
Change In Taste	Yes ☐	No ☐	Loss Of Consciousness	Yes ☐	No ☐
Trouble Hearing	Yes ☐	No ☐	Lightheaded/Dizzy	Yes ☐	No ☐
Decreasing Hearing	Yes ☐	No ☐			
Ringing In Ear	Yes ☐	No ☐	**PSYCHIATRIC**		
Pain In Ear	Yes ☐	No ☐	Anxiety	Yes ☐	No ☐
Neck Lump	Yes ☐	No ☐	Depression	Yes ☐	No ☐
Throat Pain	Yes ☐	No ☐	Suicidal Thoughts	Yes ☐	No ☐
Neck Pain	Yes ☐	No ☐			
Nasal Discharge	Yes ☐	No ☐	**HEMATOLOGIC/LYMPHATIC**		
			Excessive Bruising	Yes ☐	No ☐
LUNG/RESPIRATORY			Excessive Bleeding	Yes ☐	No ☐
Difficulty Breathing – Rest Or Exertion	Yes ☐	No ☐			
Shortness Of Breath	Yes ☐	No ☐	**ENDOCRINE**		
Cough Up Blood	Yes ☐	No ☐	Thyroid Problems	Yes ☐	No ☐
Cough	Yes ☐	No ☐	Excessive Thirst	Yes ☐	No ☐
Pain	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Home Oxygen	Yes ☐	No ☐	Flushing/Hot Flashes	Yes ☐	No ☐
HEART/CARDIOVASCULAR			**SKIN/INTEGUMENT**		
Chest Pain	Yes ☐	No ☐	Rash	Yes ☐	No ☐
Irregular Heartbeat	Yes ☐	No ☐	Inflammation	Yes ☐	No ☐
Palpitations (Racing Heart)	Yes ☐	No ☐	Mole Changes	Yes ☐	No ☐
Swelling In Feet/Ankles	Yes ☐	No ☐	Failure To Heal	Yes ☐	No ☐
			Ulcers Of The Skin	Yes ☐	No ☐
REPRODUCTIVE: FEMALE					
Sexually Active	Yes ☐	No ☐	**UROLOGIC**		
Vaginal Drainage	Yes ☐	No ☐	Frequent Urination	Yes ☐	No ☐
Vaginal Bleeding	Yes ☐	No ☐	Painful Urination	Yes ☐	No ☐
Painful Intercourse	Yes ☐	No ☐	Night Time Urination	Yes ☐	No ☐
Urinary Incontinence	Yes ☐	No ☐	Blood In Urine	Yes ☐	No ☐
			Loss Of Control	Yes ☐	No ☐
REPRODUCTIVE: MALE			Difficulty Starting	Yes ☐	No ☐
Sexually Active	Yes ☐	No ☐			
Difficult Erection	Yes ☐	No ☐	**GASTROINTESTINAL/DIGESTIVE TRACT**		
Loss Of Ejaculation	Yes ☐	No ☐	Decreased Appetite	Yes ☐	No ☐
Penile Discharge	Yes ☐	No ☐	Nausea/Vomiting	Yes ☐	No ☐
Date Of Last PSA (Prostate Test)	Yes ☐	No ☐	Fullness	Yes ☐	No ☐
Date Of Last Digital Rectal Exam	Yes ☐	No ☐	Heartburn	Yes ☐	No ☐
			Vomit Blood	Yes ☐	No ☐
AMERICAN CANCER SOCIETY			Change in Bowel Habits	Yes ☐	No ☐
If you have a cancer diagnosis, would you like to receive a Welcome Packet from the American Cancer Society?	Yes ☐	No ☐	Dark Stools/Light Stools	Yes ☐	No ☐
			Diarrhea	Yes ☐	No ☐
			Constipation	Yes ☐	No ☐
			Pain	Yes ☐	No ☐