



# Health History

Date: \_\_\_\_\_

Welcome to our practice. To help us in evaluating you, please fill out the information below to the best of your ability.

Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
 Sex:  Male  Female

**What is the reason for today's visit?** \_\_\_\_\_  
 How long have you been aware of this? \_\_\_\_\_

**Major illnesses and hospitalizations:**

- Hypertension  Other: \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Coronary Artery Disease \_\_\_\_\_

**Previous surgeries:**

- Open heart (CABG)  Carotid endarterectomy (neck)  Other: \_\_\_\_\_  
 Gallbladder Which side? \_\_\_\_\_  
 Hysterectomy  Bypass on legs \_\_\_\_\_

**Medications:** (Prescription & Non-prescription) If you have a written list, we can make a copy. Otherwise, please list.

Medication	Dose (mg)	x per day	Medication	Dose (mg)	x per day

**Allergies:** (Please list drug, food, & environmental allergies with reaction.)  
 \_\_\_\_\_  
 \_\_\_\_\_

**Cholesterol:**

Has your cholesterol been checked?  Yes  No  
 Last checked: Date \_\_\_\_\_ LDL: \_\_\_\_\_ HDL: \_\_\_\_\_

**Patient Social History:**

- Use of alcohol:  Never  Rarely  Moderate  Daily  
 Use of tobacco:  Never  Previously, but quit. (How long ago? \_\_\_\_\_)  Current (packs/day: \_\_\_\_\_)  
 Use of drugs:  Never  Yes (Type / frequency: \_\_\_\_\_)

Occupation: \_\_\_\_\_

Do you have a living will or advanced directive?  Yes  No

**Family History:** (Do you have family members with the following problems?)

Please list relationship.)

- Peripheral vascular disease \_\_\_\_\_  
 Coronary artery disease \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 Varicose veins \_\_\_\_\_  
 Venous thrombosis \_\_\_\_\_

**Exercise routine:** \_\_\_\_\_

If you have pain or breathlessness with walking, please list walking distance prior to onset of symptoms. \_\_\_\_\_

Symptoms:  leg pain  breathless  chest pain

For office use

Vital Signs  
**BP -**  
**P -**

statin  βB

**Review of Systems:** (Please indicate any personal history below.)

**Constitutional Symptoms**

Good general health lately ..... Yes No  
 Recent weight change ..... Yes No  
 Decreased appetite ..... Yes No  
 Fever/night sweats ..... Yes No  
 Fatigue/weakness ..... Yes No  
 Headaches ..... Yes No

**Eyes**

Eye disease or injury ..... Yes No  
 Wear glasses/contact lenses ..... Yes No  
 Blurred or double vision ..... Yes No  
 Glaucoma/cataracts ..... Yes No

**Ears/Nose/Throat**

Hearing loss or ringing ..... Yes No  
 Earaches or drainage ..... Yes No  
 Chronic sinus problems ..... Yes No  
 Nose bleeds ..... Yes No  
 Mouth sores ..... Yes No  
 Sore throat or voice changes ..... Yes No  
 Swollen glands in neck ..... Yes No

**Cardiovascular**

Heart trouble ..... Yes No  
 Chest pain or angina pectoris ..... Yes No  
 Previous heart attack ..... Yes No  
 Swelling of feet or hands ..... Yes No

**Respiratory**

Chronic or frequent coughs ..... Yes No  
 Spitting up of blood ..... Yes No  
 Shortness of breath ..... Yes No  
 Asthma or wheezing ..... Yes No

**Gastrointestinal**

Loss of appetite ..... Yes No  
 Change of bowel movements ..... Yes No  
 Nausea or vomiting ..... Yes No  
 Frequent diarrhea ..... Yes No  
 Constipation ..... Yes No  
 Rectal bleeding/blood in stool ..... Yes No  
 Abdominal pain ..... Yes No  
 Ulcer (stomach or duodenal) ..... Yes No

**Genitourinary**

Frequent urination ..... Yes No  
 Burning or painful urination ..... Yes No  
 Awaken at night to urinate ..... Yes No  
 Blood in urine ..... Yes No  
 Incontinence ..... Yes No  
 Kidney stones ..... Yes No  
 Sexual difficulty ..... Yes No

**Musculoskeletal**

Joint pain ..... Yes No  
 Weakness of muscles/joints ..... Yes No  
 Muscle pain or cramps ..... Yes No  
 Back pain ..... Yes No  
 Difficulty in walking ..... Yes No

**Integumentary (skin, breast)**

Rash or itching ..... Yes No  
 Change in skin color ..... Yes No  
 Change in hair or nails ..... Yes No  
 Varicose veins ..... Yes No  
 Breast pain ..... Yes No  
 Breast lump ..... Yes No

**Neurological**

Frequent headaches ..... Yes No  
 Light headed or dizzy ..... Yes No  
 Convulsions or seizures ..... Yes No  
 Numbness or tingling ..... Yes No  
 Shakes ..... Yes No  
 Paralysis ..... Yes No  
 Stroke ..... Yes No  
 Head injury ..... Yes No

**Psychiatric**

Memory loss or confusion ..... Yes No  
 Nervousness ..... Yes No  
 Depression ..... Yes No

**Endocrine**

Glandular/hormone problem ..... Yes No  
 Thyroid disease ..... Yes No  
 Diabetes ..... Yes No  
 Excessive thirst or urination ..... Yes No  
 Heat or cold intolerance ..... Yes No

**Hematologic/Lymphatic**

Slow to heal after cuts ..... Yes No  
 Bleeding or bruising tendency ..... Yes No  
 Anemia ..... Yes No  
 Blood clots ..... Yes No  
 Blood transfusion ..... Yes No  
 Enlarged glands ..... Yes No

**Allergic/Immunologic**

History of skin or adverse reaction to:  
 Penicillin or other antibiotic ..... Yes No  
 Iodine or IV contrast ..... Yes No  
 Other drugs/medications ..... Yes No

Specify: \_\_\_\_\_

Are you on dialysis? Yes No

Which dialysis center? \_\_\_\_\_

Phone number: \_\_\_\_\_

Dialysis days: M/W/F TThSat

Nephrologist: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Are you being seen by home health? Yes No

Agency: \_\_\_\_\_