Health History

PATIENT NAME_____ **BIRTHDATE**___/___/____

TODAY'S DATE____/____/____ Height_____ Weight_____

Reason for your appointment with our office_____

Duration of problem_____

PAST MEDICAL HISTORY: Please check ✓ all that apply to you or your family member listed

	YOU	FATHER	MOTHER	G'PARENT	SIBLING	CHILD
Diabetes						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Breast Cancer						
GYN Cancer (Uterine/Ovarian/Cervical)						
Colon Cancer						
Lung Cancer						
Kidney Cancer						
Prostate Cancer						
Skin Cancer						
Melanoma						
Head/Neck Cancer (Mouth/Tongue/Thyroid)						
Kidney Failure						
Thyroid Disease						
Liver Disease						
Stroke						
Stomach Ulcers						
AIDS or HIV						

Please list any other medical problems not listed above _____

_____

Please list all your previous surgeries:

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9._____ 10._____

***When was your last colonoscopy? Date_____ Performed by: Dr._____**

Please list <u>ALL</u> your medications - include dosage/strength & how often you take them:

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9._____ 10._____

11._____ 12._____

13._____ 14._____

Are you on any Blood Thinning Medications? Yes No

If yes, please circle which one you take: Aspirin Coumadin Plavix Effient

Please list any medication ALLERGIES you have:

_____

or **indicate NKDA (no known drug allergies) by checking ✓ here:** ☐

Social History:

Tobacco status ✓: never smoked _____ , former smoker_____, current everyday smoker_____, or

current smoker, occasionally_____ *How many years have you smoked?_____

Alcohol intake ✓: None_____, daily_____, weekly_____, rarely_____ *Please specify how much:_____

What is/was your occupation?_____ Are you retired? Yes No

Are you disabled? Explain_____

Good health generally?	Yes	No	Burning or painful urination?	Yes	No
Recent weight change?	Yes	No	**Who is your kidney specialist? Dr._____		
Gain _____ Loss_____			Incontinence?	Yes	No
Loss of appetite?	Yes	No	Joint pain or weakness?	Yes	No
Fever or night sweats?	Yes	No	Difficulty walking?	Yes	No
Any eye disease?	Yes	No	Memory loss or confusion?	Yes	No
History of heart trouble?	Yes	No	Excessive thirst?	Yes	No
**Who is your cardiologist? Dr._____			Excessive urination?	Yes	No
Chest Pain?	Yes	No	Heat or cold intolerance?	Yes	No
Heart Palpitations?	Yes	No	Skin or nails drier?	Yes	No
Swelling of feet, ankles, or hands?	Yes	No	Difficulty sleeping/insomnia?	Yes	No
Chronic cough?	Yes	No	**Females:**		
Cough or spitting up blood?	Yes	No	How many pregnancies have you had?_____		
Shortness of breath?	Yes	No	How many children do you have? _____		
Wheezing?	Yes	No	Did you breastfeed?	Yes	No
Change in bowel movements?	Yes	No	First child born at age?_____		
Abdominal pain?	Yes	No	Began menstrual cycle at age? _____		
Breast mass or lump?	Yes	No	When was your last menstrual cycle? _____		
			Have you had a hysterectomy?	Yes	No
			If yes, do you still have ovaries?	Yes	No
			Date of last pap smear? _____		

To the best of my knowledge, the questions on my health history sheet have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is MY responsibility to inform the doctor's office of any changes in my health status or my medications. I also authorize the healthcare staff to perform any necessary services that I may need to care for me.

_____

Signature of Patient or Parent/Guardian of Patient **Date**

_____

Signature of Physician **Date**