PATIENT HEALTH HISTORY: PLEASE COMPLETE BOTH SIDES OF THIS SHEET

Date of Visit: _____

Patient's Name_____ Age _____ Sex _____ Date of Birth _____ Right or left handed_____

Referring Doctor Name and Specialty: _____

Please list all the physicians (with phone #), in addition to the referring physician, who should receive a copy of your evaluation.

_____

Preferred pharmacy Name _____ Pharmacy phone # _____

Briefly describe your symptoms or problems. _____

PERSONAL HISTORY

Have you ever had any of the following illnesses?

High blood Pressure	No	Yes	Glaucoma	No	Yes	**Date of last Flu Vaccine?** _____
Diabetes	No	Yes	AIDS/HIV	No	Yes	
Date of last diabetic eye/foot exam _____			Stroke	No	Yes	
Heart Disease	No	Yes	Anxiety	No	Yes	
Seizures	No	Yes	Depression	No	Yes	
Migraines	No	Yes	Tuberculosis	No	Yes	
High Cholesterol	No	Yes	Meningitis	No	Yes	
Asthma	No	Yes	Polio	No	Yes	
Lung Disease	No	Yes	Thyroid Disorder	No	Yes	
Liver Disease	No	Yes	Heart Attack	No	Yes	
Kidney Disease	No	Yes	Atrial Fibrillation	No	Yes	
Reflux	No	Yes	Cancer	No	Yes*	
			*_____			

65 Years and Older:

Have you had a pneumonia vaccine?	Yes	No
When? _____		
Have you fallen in the last year?	Yes	No
Do you feel unsteady on your feet?	Yes	No
History of broken bones as an adult?	Yes	No
Fallen more than twice in the last year?	Yes	No
Sustained injuries from falling?	Yes	No
Take calcium or Vit D supplements?	Yes	No
Currently taking osteoporosis meds?	Yes	No

Others:_____
_____

Have you ever had any of the following surgeries?

Heart Surgery	No	Yes	Brain Surgery	No	Yes
Back Surgery	No	Yes	Aneurysm repair	No	Yes

Any other type of operation:

Type _____ Year _____
Type_____ Year_____

Do you have any metal or surgical implants? (i.e. pacemaker)

No
Yes _____

MEDICATIONS

Allergies: please list any allergies you have including any medication allergies: _____ **NONE**

Medications: Please list all medicines you are taking and how you actually take them. Please include all vitamins herbal supplements and birth control medications. (If you require more space, please attach additional sheets of paper or bring a list of medication with you)

	Drug Name	***Dosage***	***How many times a day?***
1			
2			
3			
4			
5			
6			
7			

Please turn over and complete the back. Thank you

SOCIAL HISTORY

Do you smoke? No Yes How many packs per day?_____ Quit (When_____)
Do you drink alcohol? No Yes How much/ what type?_____ Quit (When_____)
Occupation (or former occupation if retired) _____
Education: Years in high school _____ Years in college _____ Years in post grad. _____
Marital Status: Single Married Divorced Widowed Separated Other _____

Who lives at home with you?_____

FAMILY HISTORY

Has any blood relative ever had: (circle yes or no)			**Who**
Stroke	No	Yes	_____
Epilepsy or Seizure	No	Yes	_____
Migraine	No	Yes	_____
Multiple Sclerosis	No	Yes	_____
Heart Attack at young age	No	Yes	_____
High Blood Pressure	No	Yes	_____
Diabetes	No	Yes	_____

Others: _____

REVIEW OF SYSTEMS – Please circle and provide brief detail for the medical conditions below which apply to you currently or recently.

Constitutional - General
NONE
Weight loss
Weight gain
Change in appetite
Fever
Fatigue
Excessive Sleepiness
Unable to Sleep

Neurological
NONE
Headache
Concussion
Atrophy
Numbness
Tingling
Trouble walking
Poor balance
Trouble swallowing
Trouble chewing
Trouble talking
Falls
Vertigo
Memory loss
Loss of consciousness
Seizures
Tremor

Eyes
NONE
Blurred Vision
Double Vision
Loss of Vision
Cataracts
Glaucoma

Psychiatric
NONE
Anxiety
Mania
Depression
Psychosis

Musculoskeletal
NONE
Weakness
Neck pain
Back pain
Joint pain
Joint swelling

Cardiovascular
NONE
Chest pain
Angina
Fainting spells
Heart Murmur
Heart Failure
Leg Swelling
High/Low Blood Pressure

Respiratory
NONE
Shortness of Breath
Emphysema
Asthma
Bronchitis
Pneumonia
Chronic cough

Endocrine
NONE
Diabetes
Impotence
Thyroid disease

Skin
NONE
Rash
Moles
Tumors
Discoloration

Genitourinary
NONE
Frequent urination
Painful urination
Urinary urgency
Getting up at night to urinate (more than 2 times a night)
Blood in Urine
Urinary incontinence
Kidney Stones
Sexually Transmitted Disease _____
Impotence
Sexual Dysfunction

Gastrointestinal
NONE
Gastric ulcer
Gastric Bleeding
Abdominal pain
Diarrhea
Hepatitis
Pancreatitis
Rectal bleeding

Ear, Nose, Throat
NONE
Ringing in the ear
Hearing loss
Sinusitis
Dizziness

Hematological
NONE
Sickle cell disease
Other blood disorders
Enlarged lymph nodes