Health History Form

All information will remain confidential

Name:_______________ Age:____ Date of Birth:_______ Today's Date:________ SS#:_______________

Gender: ☐ M ☐ F Home Address:_______________ City:___________ State:_______ Zip:__________

Phones: Home# _______________ Work# _______________ Cell# _______________ Best time to reach? ☐AM ☐PM

Best number to use: ☐ Home ☐ Cell ☐ Work Primary Language: ☐ English ☐ Spanish Other ___________

Employer Name:_______________ Employer Address:_______________

Employer Phone #:_______________ Occupation:_______________ Shoe Size: ___________

Emergency contact name:_______________ Relationship:_______________ Phone #:_______________

If patient is a minor, please list:

Father's Name:_______________ Father's Employer:_______________

Mother's Name:_______________ Mother's Employer:_______________

Insurance Information

Primary Insurance:

Company Name:_______________ Company Address:_______________ Phone #:_______________

Name of Policy Holder:_______________ Policy Holder's DOB:_______________ SS#:_______________

Identification #:_______________ Group #:________ Copay:_______________ Type of Plan:_______________

Secondary Insurance:

Company Name:_______________ Company Address:_______________ Phone #:_______________

Name of Policy Holder:_______________ Identification #:_______________ Group #:_______________

Copay:_______________ Type of Plan:_______________

Workers Compensation

If your employer/ Workers Compensation Carrier has sent you for evaluation/ treatment, please complete the following:

Type of injury sustained: (i.e. broken leg, back pain etc.)_______________

Date of Injury: (required)_______________ Employer's name and address at time of injury:_______________

_______________ Contact Name:_______________ Contact Phone #:_______________

Workers Compensation Carrier:_______________ Address:_______________

Contact Name:_______________ Contact Phone #:_______________

Auto Accident

If you are here as a result of an automobile accident, then please fill out the following:

Date of Accident:_______________ Describe the injury and or pain that you have:_______________

____

Auto Insurance Company:_______________ Address:_______________

Phone #:_______________ Claim Number:_______________

If we are filing your medical claims to your medical insurance company, please fill out the primary insurance information section above. Remember to submit your insurance card to the receptionist so that we may have a copy of your current insurance on record.

Assignment of Insurance Benefits And Authorization to obtain or release patient information

I hereby authorize the physician's office to release such information as may be necessary for claims to the insurance companies listed above. I also hereby authorize payment directly to the physician for any benefits otherwise payable directly to me, but not to exceed the regular charges for this period. I am financially responsible to the above physicians for charges not covered by the assignment. Patients not covered by insurance are responsible at the time of service for charges incurred or arrangements for payment must be made with the business office.

I authorize the physician's office to release or obtain such information as may be necessary to assist in my medical treatment

Signature:_______________ Date:_______________

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Name ____________________

Symptoms / Systems Review
Check the symptoms your currently **have or had in the past year)**

General:
- ❑ **None**
- ❑ Chills / sweats / fever
- ❑ Forgetfulness
- ❑ Headaches
- ❑ Unexplained weight loss

Cardiovascular:
- ❑ **None**
- ❑ Chest pain
- ❑ Irregular Heart Beat
- ❑ Swelling of Ankles

Respiratory:
- ❑ **None**
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Persistent cough
- ❑ Snoring

Neurological/Mental Health:
- ❑ **None**
- ❑ Learning Disability
- ❑ Dizziness/Fainting
- ❑ Panic Attack
- ❑ Claustrophobia
- ❑ Emotional Illness
- ❑ Numbness / Tingling: Where? ____________

Gastrointestinal:
- ❑ **None**
- ❑ Appetite poor
- ❑ Bowel changes
- ❑ Indigestion
- ❑ Nausea / Vomiting
- ❑ Rectal Bleeding
- ❑ Vomiting blood

Genito-Urinary:
- ❑ **None**
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

Endocrine:
- ❑ **None**
- ❑ Heat or cold intolerance
- ❑ Excessive thirst

Blood Disorders:
- ❑ **None**
- ❑ Bruise easily
- ❑ Prior Blood Transfusions

Eye:
- ❑ **None**
- ❑ Eye problems
- ❑ Blurred Vision
- ❑ Double vision

Ear, Nose, Throat:
- ❑ **None**
- ❑ Ear problems
- ❑ Loss of hearing
- ❑ Loss of balance
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Sinus problems

Muscle/Joint/Bone:
- ❑ **None**
- ❑ Joint pain: where? ____________
- ❑ Difficulty walking
- ❑ Limited movement: Where? ____________

Skin:
- ❑ **None**
- ❑ Change in moles
- ❑ Rash
- ❑ Sore that won't heal
- ❑ Open wound

Men only:
- ❑ **None**
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other

Women only:
- ❑ **None**
- ❑ Bleeding between periods
- ❑ Breast lump / pain
- ❑ Extreme menstrual pain
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Other

Date of last:
Menstrual period ________
Pap smear ________
Mammogram ________
Are you pregnant? ________
Number of children ________
Number of pregnancies ____
Complications if any ______
____

Other:
____
____

❑ All Other Systems are Negative

Health Habits
Check which substances you use and describe how much you use.

❑ Alcohol ____________ ❑ Illicit drugs ____________ ❑ Other ____________
❑ Caffeine ____________ ❑ Tobacco ____________

Occupational Concerns
Check if your work exposes you to the following:

❑ Hazardous Substances ❑ Heavy lifting ❑ Stress ❑ Other ____________

Your occupation: ____________

Do you live with your family / spouse? ________ If not, will you need assistance after your surgery? ________

Family History
(Close blood relatives) Check all that apply

❑ Heart Disease	❑ Diabetes	❑ Cancer Type: ________	❑ Thyroid Disease	❑ Neurological
❑ High Blood Pressure	❑ Tuberculosis	❑ Kidney Disease	❑ Blood Disease	❑ Mental Illness

Name ____________________

Conditions / Past Medical History - Check all that apply

Cardiac
- ❑ **None**
- ❑ Congestive Heart Failure
- ❑ Heart Disease/ Attack
- ❑ High Cholesterol
- ❑ High Blood pressure
- ❑ Mitral Valve Prolapse
- ❑ Valve Disease
- ❑ Pacemaker / ICD **(Bring implant card with you)**
- ❑ Rhythm disturbances

Endocrine
- ❑ **None**
- ❑ Diabetes
  Circle : Diet / Pill / Insulin /Pump
- ❑ Thyroid Problems / Goiter
- ❑ Adrenal disease

Cancer or Tumor
- ❑ None
- ❑ Type___________
- ❑ Chemo ___________
- ❑ Radiation ___________

Musculoskeletal
- ❑ **None**
- ❑ Arthritis
- ❑ Gout
- ❑ Limited movement
- ❑ Multiple sclerosis
- ❑ Muscular dystrophy
- ❑ Back / neck Problems
- ❑ Fractures
- ❑ Fibromyalgia
- ❑ Myasthenia Gravis

Bleeding / Circulation
- ❑ **None**
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Blood clots / DVT
- ❑ Poor circulation
- ❑ Phlebitis
- ❑ Sickle Cell

Respiratory
- ❑ **None**
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Pneumonia
- ❑ Sleep Apnea
- ❑ CPAP - Y / N?
- ❑ TB

Genitourinary
- ❑ **None**
- ❑ Kidney Failure
- ❑ Dialysis
- ❑ Kidney Stones
- ❑ Prostate/testicle problem
- ❑ Urinary Tract Infection

Skin
- ❑ **None**
- ❑ Rashes: Where? ________

Breast
- ❑ None
- ❑ Lumps
- ❑ Nipple Discharge
- ❑ Breast Pain
- ❑ Abnormal Mammogram

Infectious Diseases
- ❑ **None**
- ❑ History of Wound Infection
- ❑ Recent Mono
- ❑ HIV
- ❑ Hepatitis
- ❑ MRSA
- ❑ VRE
- ❑ C Diff

Neurological/Mental Health
- ❑ **None**
- ❑ Stroke / Mini (TIA)
- ❑ Seizures
- ❑ Migraine headaches
- ❑ Chemical dependency
- ❑ Depression / Anxiety
- ❑ Paralysis
- ❑ Back Disc Disorder

Gastrointestinal
- ❑ **None**
- ❑ Reflux
- ❑ Hernia
- ❑ Ulcers
- ❑ Hepatitis
- ❑ Liver disease

Hearing & Vision
- ❑ **None**
- ❑ Hearing loss
- ❑ Glaucoma
- ❑ Cataract

Implantable Devices
- ❑ **None**
- ❑ Ports/Pumps
- ❑ Other (list)

Important!
Bring implant card with you.

Past Surgery Check all that apply

❑ **None**	❑ Cataract L R	❑ Heart Valve	❑ Prostate	List any other:
❑ Amputation	❑ Colon Resection	❑ Hemorrhoidectomy	❑ Sinus	
❑ Aneurysm (AAA)	❑ Cysto	❑ Hernia	❑ Spine (Back/Neck	
❑ Angioplasty	❑ D & C	❑ Hysterectomy	❑ Splenectomy	
❑ Appendectomy	❑ Fem/Pop Bypass	❑ Kidney removal	❑ Tonsils & Adenoids	
❑ Arthroscopy	❑ Gallbladder	❑ Laparoscopy	❑ Total Hip L R	
❑ Breast Biopsy	❑ Heart Bypass	❑ Mastectomy L R	❑ Total Knee L R	
❑ Carotid	❑ Heart Cath	❑ Pacemaker / AICD	❑ Tubal Ligation	

Allergies Check all that apply

❑**None**	❑ Penicillin	❑ Morphine	❑ Novocaine	❑ Iodine	❑ Latex	❑ Adhesive/Tape
	❑ Sulfa	❑ Demerol	❑ Codeine	❑ Aspirin	❑ Foods (List)______________	

Other:

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Name ____________________

Medications List **all medications with dosage** you are currently taking (including over the counter, inhalers, eye drops, aspirin, herbs) or attach a list of your medications

______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Taken Prednisone / Steroids on regular basis in last year? ❑ Yes ❑ No

Current Immunizations: ❑ Tetanus _______ ❑ Pneumonia _______ ❑ Flu _________

Anesthesia	Yes	No	?	Comments
Have you ever had anesthesia?				
Have you ever had a problem with anesthesia including malignant hyperthermia or difficulty placing breathing tube?				
Has any member of your family had a problem with anesthesia?				
Loose, capped or broken teeth: bridges or dentures?				
Trouble opening mouth or jaw clicking?				
Do you have problems with limited neck mobility?				
Do you have shortness of breath after walking up 1 flight of stairs?				
Do you smoke?				# packs per day____ # years_______
Are you an ex-smoker? When stopped?				# packs per day____ # years_______
Do you drink alcoholic beverages?				How often______ how much______
Do you use any street drugs?				
Have you ever had a blood transfusion?				If "yes", what year(s)?
Do you have problems with chronic pain?				
Any religious/cultural practices we should know about ?				
Do you have an advanced directive (living will)?				
Females: Is there a chance you could be pregnant?				

Pharmacy Information:

Name of Pharmacy____

Location ______________________ Phone #__________________

Name ____________________

Other Physicians Please list all physicians that are presently treating you.		
Primary Care Physician ____________________ Office # ____________________ Date Last Seen ____________________	Cardiologist ____________________ Office # ____________________ Date Last Seen ____________________	Other Physician(s)

History of Present Illness

What is the reason for your visit? ____________________

When did you first notice the problem? ____________________

How did the problem begin? ____________________

Have you had this problem before? ❑ Yes ❑ No

Is the problem painful? ❑ Yes ❑ No

Were you treated for this problem before? ❑ Yes ❑ No

Location? ____________________

Does it interfere with regular activities? ❑ Yes ❑ No

Intensity of the pain: 0 1 2 3 4 5 6 7 8 9 10

Character of the pain: (circle those that apply):

Sharp Dull Constant Intermittent

What makes it worse? ____________________

What makes it better? ____________________

Have you recently experienced: ❑ Fever ❑ Chills ❑ Nausea / Vomiting ❑ Weight loss ❑ Night sweats

Comments:

____

____

____

____

Information provided by ____________________ **Relationship to Patient** ____________ **Date** ________