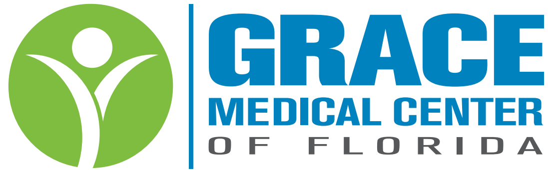

Patient Health History Form

Patient Name Birth Date (mm/dd/yyyy)

Reason for today's visit:

When did symptoms begin?

Location: ______________________________

Onset: Select One: ❑ Gradual ❑ Sudden ❑ Other

Duration: ______________________________

Severity: Select one: ❑ Mild ❑ Moderate ❑ Severe ❑ Incapacitating ❑ Other

Context: (when walking, etc.) ______________________________

Status: Select one: ❑ New Diagnosis ❑ Improving ❑ Stable ❑ Worsening ❑ Resolved

Aggravating Factors: Relieved By:

List Any Chronic Conditions:

Condition	Date of Onset	Condition	Date of Onset
Anemia		Eye Problems	
Anxiety		Gastroesophageal Reflux Disorder	
Arthritis		Headaches	
Bladder Infections		Heart Attack (Myocardial Infarction)	
Cancer ______________ (Type)		Hepatitis	
Chronic Obstructive Pulmonary Disease		Hypertension	
		Insomnia	
Constipation/Diarrhea		Irritable Bowel Syndrome	
Depression		Stroke	
Diabetes Type 1		Thyroid Diseases	
Diabetes Type 2		Other	

List Any Medications You Are Currently Taking (including non-prescription or over the counter vitamins or supplements)	
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Do you have any current allergies (including medications, food, animal, plant or environmental)?	
1.	
2.	
3.	
4.	

Please indicate any past medical history:		
❏ Allergies (seasonal)	❏ COPD	❏ Irritable Bowel Disease
❏ Anemia	❏ Coronary Artery Disease	❏ Liver Disease
❏ Angina	❏ Crohn's Disease	❏ Migraines
❏ Anxiety	❏ Depression	❏ MI/Heart Attack
❏ Arthritis	❏ Diabetes	❏ Osteoarthritis
❏ Asthma	❏ Gallbladder Disease	❏ Osteoporosis
❏ Atrial Fibrillation	❏ GERD	❏ Peptic Ulcer Disease
❏ Benign Prostatic Hypertrophy	❏ Hepatitis C	❏ Renal Disease
❏ Blood Clots	❏ Hyperlipidemia	❏ Seizure Disorder
❏ Cancer ____________ Type	❏ Hypertension	❏ Thyroid Disease
❏ Cerebrovascular Accident		
Other:		

Please indicate any past surgical history:

❑ Angioplasty	Year ____________	Hernia Repair	Year ___________
❑ Angio w/Stent	Year ____________	Hip Replacement	Year ___________
❑ Appendectomy	Year ____________	Knee Replacement	Year ___________
❑ Back Surgery	Year ____________	LASIK Year	
❑ CABG	Year ____________	Liver Biopsy	Year ___________
❑ Carpal Tunnel Release	Year ____________	ORIF Year	
❑ Cataract Extraction	Year ____________	Pacemaker	Year ___________
❑ Cholecystectomy	Year ____________	Small Bowel Resection	Year ___________
❑ Colectomy	Year ____________	Thyroidectomy	Year ___________
❑ Colostomy	Year ____________	Tonsillectomy	Year ___________
❑ Gastric Bypass	Year ____________		

Other:

Family History

Relation	Alive & Well (y/n)	Condition/Diagnosis	Age on Onset	Cause of Death (y/n)
1.				
2.				
3.				
4.				
5.				
6.				

Social History – Tobacco Usage				
Use Tobacco:	**Type:**	**Quantity per day:**	**Year(s) Used:**	**Have you ever tried to quit? (y/n)** ______
❑ Current	❑ Chewing	______________	______________	Year Quit:
❑ Former	❑ Cigar			______________
❑ Never	❑ Cigarettes			
❑ Unknown	❑ Pipe			
	❑ Smokeless			
	❑ Snuff			

Social History – Alcohol		
Yes / No/ Former	**If Yes, Type:**	**Frequency:**
______________	______________	______________
If Former, When Quit?	**Amount:**	**Last Drink:**
______________	______________	______________

Social History – Caffeine		
Use:	**Type:**	**Quantity per day:**
❑ Yes	❑ Chocolate	______________
❑ No	❑ Coffee	
	❑ Energy Drinks	
	❑ Soda	
	❑ Tablets	
	❑ Tea	

Patient Signature: Date: