

PATIENT HEALTH HISTORY FORM

DATE: _____

NAME: _____ DOB: _____

PHONE NUMBER WHERE WE CAN REACH YOU DURING THE DAY: _____

PHONE NUMBER WHERE WE CAN LEAVE A DETAILED MESSAGE: _____

MEDICATIONS: (Please list all medications, dose and frequency)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

LIST MEDICATION ALLERGIES? _____ None

OTHER ALLERGIES? FOOD _____ LATEX _____ OTHER _____

HEIGHT: _____ **WEIGHT:** _____ **BP:** _____ **TEMP:** _____ **PULSE:** _____

MEDICAL HISTORY : HIGH BLOOD PRESSURE CANCER HEART DISEASE DIABETES
 BLOOD CLOTS/BLEEDING PROBLEMS SLEEP APNEA OTHER _____

HISTORY OF ANY SURGERY:

HAVE YOU OR ANY RELATIVES HAD A PROBLEM WITH ANESTHESIA? YES NO _____
HAVE YOU EVER HAD AN EKG? YES NO WHY _____
WHEN/WHERE _____

SOCIAL HISTORY:

YOU LIVE ALONE W/SPOUSE W/FAMILY APT/CONDO HOUSE ASSISTED LIVING
PREGNANT YES NO LAST MENSTRUAL PERIOD: _____
CAFFEINE YES NO HOW MUCH: _____
TOBACCO USE YES NO HOW MUCH: _____
ALCOHOL/DRUG USE YES NO TYPE/FREQUENCY: _____
DO YOU EXERCISE? YES NO FREQUENCY: _____
HOW FAR CAN YOU WALK COMFORTABLY _____ BLOCKS _____ MILES
CAN YOU CLIMB STAIRS? NO YES WITHOUT ASSISTANCE WITH ASSISTANCE

MORE ON BACK ↓

REVIEW OF SYSTEMS

HEENT (Head, Eyes, Ears, Nose, Throat)

- Yes No Headache
- Yes No Hard of hearing/Hearing aid
- Yes No Dentures/Caps/Loose teeth
- Yes No Jaw/Neck, range of motion
- Yes No Vocal cord problems
- Yes No Eye trauma
- Yes No Double vision
- Yes No Contact Lenses/Glasses

NEUROLOGIC

- Yes No Numbness
- Yes No Balance problems
- Yes No Seizures
- Yes No Weakness
- Yes No Memory loss
- Yes No Stroke
- Yes No Psychiatric problems

RESPIRATORY

- Yes No Recent cold/cough
- Yes No Wheezing
- Yes No Shortness of breath/Asthma, COPD

SKIN

- Yes No Lesions
- Yes No Rash
- Yes No Scars
- Yes No Masses
- Yes No Eczema

CARDIOVASCULAR

- Yes No Murmur/Irregular rhythm
- Yes No Pacemaker/AICD
- Yes No Congestive failure
- Yes No Swelling of ankles

URINARY

- Yes No Renal failure
- Yes No Hesitancy
- Yes No Pain
- Yes No Incontinence
- Yes No Kidney stones
- Yes No Bladder infections

GASTROINTESTINAL

- Yes No Reflux Heartburn
- Yes No Ulcers
- Yes No Liver problems/Hepatitis/Jaundice
- Yes No Nausea/vomiting
- Yes No Diarrhea
- Yes No Communicable diseases
- Yes No Constipation/Pain
- Yes No Blood in stool

METABOLIC

- Yes No Weight gain
- Yes No Thyroid problem
- Yes No Nutritional problem
- Yes No Weight loss
- Yes No Fatigue

MUSCULOSKELETAL

- Yes No Arthritis
- Yes No Paralysis
- Yes No Physical limitations
- Yes No Artificial limbs

FAMILY HISTORY

- Yes No Blood Clots/Bleeding Disorder
- Yes No Cancer
- Yes No Diabetes
- Yes Other _____
- Yes No Heart Disease
- Yes No High Blood Pressure/Hypertension
- Yes No Sleep Apnea

PRINT PATIENT NAME: _____ D.O.B. _____

PATIENT SIGNATURE: _____ DATE: _____ DR. SIGNATURE: _____ DATE: _____

REVIEWED BY PATIENT: _____ REVIEWED BY PATIENT: _____ REVIEWED BY PATIENT: _____
Initial Date Initial Date Initial Date

REVIEWED BY DOCTOR: _____ REVIEWED BY DOCTOR: _____ REVIEWED BY DOCTOR: _____
Initial Date Initial Date Initial Date

ASC REVIEWED BY: _____ DATE: _____