patient health history

This information will be kept confidential.

Patient Information

Last name _____ First name _____

Date of Birth _____/_____/_____

Sex ☐ female ☐ male

Date of last physical examination _____/_____/_____

What is your reason for today's visit? _____

_____

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding disorder
☐ Cancer
☐ Cataracts
☐ Depression
☐ Diabetes
☐ Emphysema/COPD
☐ GERD
☐ Glaucoma
☐ Gout
☐ Headache
☐ Hearing loss
☐ Heart disease
☐ Heart murmur
☐ Hepatitis
☐ High blood pressure
☐ High cholesterol
☐ HIV/AIDS
☐ Kidney disease
☐ Liver disease
☐ Nerve or muscle disease
☐ Psychiatric
☐ Obesity
☐ Osteoporosis
☐ Pneumonia
☐ STI (herpes, chlamydia, etc.)
☐ Seizures/Epilepsy
☐ Sleep apnea
☐ Stroke
☐ Substance abuse
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers
☐ UTI
☐ Vision problems

Other significant illnesses not listed:_____

_____

_____

Surgeries/Hospitalizations: Please check if you had surgery or hospitalization for the following and indicate the year:

☐ Appendix _____
☐ Bariatric surgery _____
☐ Breast surgery _____
☐ C-section _____
☐ Cataract surgery _____
☐ Colon surgery _____
☐ Eye surgery _____
☐ Fracture surgery _____
☐ Heart surgery _____
☐ Hernia repair _____
☐ Gallbladder _____
☐ Hysterectomy _____
☐ Joint surgery _____
☐ Kidney/bladder _____
☐ Ovary/Prostate surgery_____
☐ Spine surgery _____
☐ Tonsils _____
☐ Tubal ligation _____

Please list any other significant surgeries or other hospitalizations for any reason:_____

_____

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Medical History: Please check if you have or have ever had any of the following:

Medications: Including supplements, OTC, etc., with dose and how taken.

Drug Name	Strength	Instructions

Allergies:

Type of Allergy	Reaction

Health Maintenance: Please check and list date performed.

☐ Tetanus _____	☐ Pneumonia 13 _____	☐ Pap _____
☐ Tdap _____	☐ Pneumonia 23 _____	☐ Mammogram _____
☐ Influenza vaccine _____	☐ Eye exam _____	☐ Bone density _____
☐ Shingles vaccine _____	☐ Cholesterol _____	☐ Colonoscopy _____

Family History: List which family member has had any of the following.

Diagnosis	Relationship	Diagnosis	Relationship
Alcohol abuse		Hearing loss	
Arthritis		Heart disease	
Asthma		High cholesterol	
Cancer		Hypertension	
COPD		Kidney disease	
Dementia		Mental illness	
Depression		Stroke	
Diabetes		Vision loss	
Drug abuse		Other	

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A Hill Physicians Practice

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Family History (cont'd): Please indicate the present health of your family members.

Relative	Alive	Dead	Age (for deceased)	Chronic Health Problems	Cause of Death
Father	☐	☐	_____	_____	_____
Mother	☐	☐	_____	_____	_____
Brother / Sister	☐	☐	_____	_____	_____
Brother / Sister	☐	☐	_____	_____	_____
Brother / Sister	☐	☐	_____	_____	_____
Brother / Sister	☐	☐	_____	_____	_____

Social and Personal History: Answering these confidential questions honestly will allow an accurate assessment of your health risks.

Current occupation _____ Education completed _____

Marital status: ☐ single ☐ married ☐ widowed ☐ divorced ☐ domestic partner

I currently live with _____

Tobacco use:

Do you currently use tobacco products? ☐ yes ☐ no

If yes, type and frequency:

☐ cigarette ☐ cigar ☐ smokeless tobacco ☐ other #/day_____ years_____

Former smoker: ☐ yes ☐ no #/day_____ years_____ quit date _____/_____/_____

Alcohol use:

Do you drink alcohol? ☐ yes ☐ no

per week: _____ glasses of wine _____ cans of beer _____ shots of liquor

Drug use:

Do you currently use drugs? ☐ yes ☐ no Have you used drugs in the past? ☐ yes ☐ no

Type: _____ Use/week: _____

Sexually active:

Are you sexually active? ☐ yes ☐ no Partners: ☐ female ☐ male

Birth control/protection: _____

Exercise regularly:

Do you exercise? ☐ yes ☐ no What type? _____ Times/week _____

Use sunscreen:

Do you use sunscreen? ☐ yes ☐ no