

Patient Health History

Name: _____

DOB: _____

Age: _____

Past Medical History:

Please check all that apply:

- Anemia
- Bleed/Bruise easily
- Blood Clots/Phlebitis
- Cancer
- Enlarged lymph nodes
- Stroke
- Seizures
- Migraine Headaches
- Glaucoma
- Diabetes
- Thyroid disorders
- Hives or Eczema
- Asthma
- Bronchitis
- Emphysema
- Pneumonia

- Circulatory Problems
- Heart attack
- Heart disease
- Heart rhythm problems
- Mitral Valve Prolapse
- High Blood Pressure (Hypertension)
- Low Blood Pressure
- Hepatitis
- Liver disease
- Kidney problems
- Urinary infections
- Hemorrhoids
- Hernia
- Ulcers
- Arthritis
- Fibromyalgia

- Emotional Problems
- Substance abuse

Infections:

- Measles
- Mumps
- Chicken Pox
- Whooping cough
- Scarlet fever
- Diphtheria
- Small pox
- Tuberculosis
- Rheumatic fever
- Infectious mono
- AIDS or HIV
- Venereal Disease

Other _____

Past Surgical History:

- Never had Surgery
- Had Surgery

Reason for Surgery: _____

Location: _____

Date: _____

Procedures:

- Never had a colonoscopy
- Had a colonoscopy. Date: _____ (month/year)
- Had other colorectal cancer screening. Test: _____ Date: _____ (month/year)

Patient Health History

Name: _____

DOB: _____

Gynecologic History:

*Are you Pregnant: Y / N

Number of pregnancies(Gravida): _____

Number of deliveries(Para): _____

Age at first Birth: _____

of interrupted pregnancies: _____

Miscarriages: _____

Abortions: _____

Age at first period: _____

Age at menopause: _____

Hormone Use

Contraceptive Use # years _____

Post Menopausal Use # years _____

Other Hormone Use # years _____

Date of last PAP: _____

Date of last Mammogram: _____(m/d/y)

Family History:

Biological Father

Age: _____

Living Deceased Unknown

Cause of Death: _____

Medical Problems: _____

Biological Mother

Age: _____

Living Deceased Unknown

Cause of Death: _____

Medical Problems: _____

Biological Brother(s)

of living brothers: _____ Age(s): _____

of deceased brothers: _____ Age(s): _____

Cause of Death: _____

Medical Problems: _____

Biological Sister(s)

of living sisters: _____ Age(s): _____

of deceased sisters: _____ Age(s): _____

Cause of Death: _____

Medical Problems: _____

Biological Children

of living sons: _____ daughters: _____

of deceased sons: _____ daughters: _____

Cause of Death: _____

Medical Problems: _____

Other Family Medical History (including cancer)

Social History:

Occupation: _____

Marital Status:

- Single
- Married
- Separated
- Divorced
- Widowed

Smoking Status:

- Yes - current every day smoker
- Yes - current some day smoker
- Yes - but quit (former smoker)
- Never
- Smoker - current status unknown
- Unknown if ever smoked
- Heavy tobacco smoker (>10 cig/day)
- Light tobacco smoker (<10 cig/day)

Smoked since date:

(m/d/yr) _____

#Packs/Day _____

Quit Since Date:

(m/d/yr) _____

Alcohol Consumption:

- Yes - every day drinker
- Yes - some day drinker
- Yes - active
- Yes - but quit
- Never
- Status unknown
- Unknown if ever drank
- # Drinks/Day _____
- # Days/Week _____
- Quit since date: _____
- (m/d/yr)

Review of Systems

Name: _____

DOB: _____

Constitutional Symptoms

- Weight Loss
- Weight Gain
- Loss of appetite
- Fever/Chills
- Night sweats
- Fatigue
- Headache

Skin

- Rash
- Itching
- Changes in skin color
- Changes in hair or nails
- Changes in Mole(s)
- Varicose veins

Eyes

- Visual Problems
- Blurred or double vision
- Eye Disease or Injury
- Wear glasses/
contact lenses

Ears/Nose/Throat/

- Hearing loss or ringing
- Earaches or drainage
- Chronic sinus problems
- Nose bleeds
- Mouth sores
- Bleeding gums
- Bad breath or bad taste
- Sore throat
- Voice Changes

Heart/Lungs

- Chest pain
- Palpitations
- Short of breath
- Short of breath at night
- Short of breath
- worse with exertion
- Cough
- Cough up blood
- Swelling in legs, feet,
or hands
- Wheezing

Gastrointestinal

- Loss of appetite
- Abdominal pain
- Nausea or Vomiting
- Diarrhea
- Constipation
- Painful bowel movements
- Rectal bleeding/blood in stool
- Special Diet

Urinary

- Frequent urination
- Painful urination
- Lack of control/incontinence
- Blood in urine
- Kidney Stone

Musculoskeletal

- Joint pain/swelling
- Muscle pain/swelling
- Back pain
- Bone pain
- Difficulty walking
- Cold extremities

Neurological/Emotional

- Headaches
- Dizziness
- Seizures
- Jerking/twitching
- Numbness/tingling
- Anxiety
- Depression
- Fainting Spells
- Confusion
- Memory loss
- Insomnia

Endocrine

- Excessive Thirst
- Excessive Urination
- Cold intolerance
- Heat intolerance
- Thyroid condition

Gynecological

- Vaginal bleeding
- Changes in Menses
- Discharge

Length of last menses:

Comments:
