

PATIENT HEALTH HISTORY

Name: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

Gender Identity: _____

Employer: _____

Occupation: _____

Highest Education Completed: ☐ High School/GED ☐ 2yr College ☐ 4yr College ☐ Post Graduate

Household members (spouse, children, parents, etc.): _____

MEDICAL HISTORY

Place check mark beside each condition that you are being, or have been, treated for; comment as appropriate.

Sensory

- ☐ Vision Loss
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Loss of Taste/Smell

Respiratory

- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Recurrent Bronchitis
- ☐ Pneumonia
- ☐ Chronic Allergies

Cardiovascular

- ☐ Coronary Artery Disease
- ☐ Angina
- ☐ Arrhythmia
- ☐ Heart Failure
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Cardiac Procedure/Surgery

Gastrointestinal

- ☐ Heartburn/GERD
- ☐ Stomach/Small Bowel Ulcer
- ☐ IBS
- ☐ Inflammatory Bowel Disease
- ☐ Hemorrhoid
- ☐ Chronic Diarrhea/Constipation
- ☐ Colon Polyps

Endocrine

- ☐ Diabetes 1 or 2
- ☐ Gestational Diabetes
- ☐ Thyroid Disorder
- ☐ Adrenal Disorder
- ☐ Hormone Disorder

Musculoskeletal

- ☐ Arthritis
- ☐ Gout
- ☐ Spine Problem
- ☐ Muscle Condition
- ☐ Osteoporosis
- ☐ Lupus
- ☐ Rheumatoid Arthritis

Neurological

- ☐ Headache/Migraine
- ☐ Seizure
- ☐ Tremor
- ☐ Memory Loss
- ☐ Stroke
- ☐ Multiple Sclerosis

Skin

- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Nail Disorder
- ☐ Skin Cancer
- ☐ Melanoma

Mental Health

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ PTSD
- ☐ OCD
- ☐ ADHD
- ☐ Schizophrenia

Genitourinary

- ☐ Kidney Disease/Stones
- ☐ Bladder Condition
- ☐ Urinary Incontinence
- ☐ Prostate Disorder
- ☐ Recurrent Urinary Infection
- ☐ Sexual Dysfunction
- ☐ Sexually Transmitted Infection

Obstetric History (Female Only)

Menses Start Age: _____

☐ Regular ☐ Irregular

Menopause Age: _____

of Pregnancies: _____

of Live Births: _____

of Vaginal Deliveries: _____

of C-Section Deliveries: _____

Miscarriages/Terminations: _____

of D&C: _____

Cancer Type and Treatment: _____

Comments: _____

SURGICAL HISTORY List past surgeries with year and place performed (include colonoscopy).

SOCIAL HISTORY

Exercise

What do you currently do for exercise? _____ Frequency: _____

Nutrition

Any current restrictive eating plan: _____ Weight Loss Medication: _____

Substances

Nicotine: ☐ Current ☐ Past ☐ Never Frequency (per day): _____
Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew ☐ Vape
Alcohol: ☐ Current ☐ Past ☐ Never Type: ☐ Beer ☐ Wine ☐ Hard Liquor Drinks(per week): _____
Marijuana: ☐ Current ☐ Past ☐ Never Method of Use: _____ Frequency: _____
Kratom: ☐ Current ☐ Past ☐ Never
Mushrooms: ☐ Current ☐ Past ☐ Never Other Substances: _____
Cocaine: ☐ Current ☐ Past ☐ Never
Heroin: ☐ Current ☐ Past ☐ Never Needle Use: ☐ Yes ☐ No
Meth: ☐ Current ☐ Past ☐ Never DUI: ☐ Yes ☐ No
Recovering from Addiction: ☐ No ☐ Yes Treatment Type: _____

Sexual Life

Sexually Active: ☐ Yes ☐ No
Sexual Partner(s): ☐ Single ☐ Multiple ☐ Male ☐ Female ☐ Other: _____
Preventive Practice(s): ☐ Birth Control, Type: _____ ☐ Condoms/Barrier
Sexual Health Concerns: ☐ No ☐ Yes, Type: _____

Sleep

Restorative Sleep: ☐ Yes ☐ No Snoring: ☐ Yes ☐ No
Consistent Sleep: ☐ Yes ☐ No Sleep Aids: ☐ Yes ☐ No

Advanced Directive

Do you currently have an Advanced Directive? ☐ Yes ☐ No

FAMILY HISTORY

Complete the known medical history of genetic family.

Adopted: ☐ Yes ☐ No

Father: ☐ Deceased _____
Mother: ☐ Deceased _____
Siblings: ☐ Deceased _____
Grandparents: ☐ Deceased _____
Grandparents: ☐ Deceased _____
Other: _____

MEDICATIONS Bring all of your current medications and supplements with you for your appointment.

ALLERGIES

Are you allergic to any medications? ☐ No ☐ Yes; list medication(s) & reaction(s) _____

Do you have any concerns regarding adequate food, clothing, housing or transportation? ☐ Yes ☐ No

Do you feel safe in your home (physically/emotionally/sexually)? ☐ Yes ☐ No History of abuse? ☐ Yes ☐ No

List anything about your health that you think your provider should know:

Reviewed by: _____ Date: _____