New Patient Health History Form (Adult)

PRAIRIE STAR Health Center

REASON FOR VISIT		TODAY'S DATE	
LAST NAME	FIRST	DATE OF BIRTH	AGE
MARITAL STATUS MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED/WIDOWERED		OCCUPATION	
PRIMARY CARE PROVIDER		PREFERRED PHARMACY	
SPECIALIST(S) YOU ARE CURRENTLY SEEING			

MEDICATIONS

CURRENT MEDICATIONS (attach additional pages if necessary)	DOSE	FREQUENCY

LIST ALL MEDICATION ALLERGIES

LIST ALL SURGERIES, INCLUDING YEAR

PAST AND PRESENT MEDICAL PROBLEMS (PLEASE CHECK AND DESCRIBE)

CARDIOVASCULAR
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART ATTACK
- ☐ HIGH CHOLESTEROL
- ☐ HEART DISEASE
  DESCRIBE:
- ☐ NO PROBLEMS

GASTROINTESTINAL
- ☐ ACID REFLUX, GERD
- ☐ DIVERTICULOSIS
- ☐ COLON POLYPS
- ☐ HEMORRHOIDS
- ☐ LIVER DISEASE
  DESCRIBE:
- ☐ IRRITABLE BOWEL
- ☐ HERNIA
  DESCRIBE:
- ☐ BOWEL DISEASE
  DESCRIBE:
- ☐ NO PROBLEMS

GENITOURINARY
- ☐ URINARY INCONTINENCE
- ☐ PROSTATE ENLARGEMENT
- ☐ GYNECOLOGICAL DISEASE
  (uterus, cervix, ovaries)
  DESCRIBE:
- ☐ STD
  DESCRIBE:
- ☐ KIDNEY DISEASE
  DESCRIBE:
- ☐ NO PROBLEMS

EENT
- ☐ CATARACT
- ☐ GLAUCOMA
- ☐ VISION PROBLEM
- ☐ HEARING PROBLEM
- ☐ SINUSITIS / ALLERGIES
- ☐ DENTURES / IMPLANTS
- ☐ NO PROBLEMS

INFECTIOUS DISEASE
- ☐ HISTORY OF CHICKEN POX
- ☐ HISTORY OF TUBERCULOSIS
- ☐ HIV
- ☐ HEPATITIS: ☐ A ☐ B ☐ C
- ☐ NO PROBLEMS

NEUROPSYCHIATRIC
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ MOOD DISORDER:
  DESCRIBE:
- ☐ SEIZURES
- ☐ MEMORY PROBLEM
- ☐ MIGRAINE
- ☐ NEUROPATHY
- ☐ STROKE
- ☐ NO PROBLEMS

OTHER PROBLEMS NOT LISTED

ENDOCRINE
- ☐ THYROID DISEASE: ☐ HYPO ☐ HYPER
- ☐ DIABETES
- ☐ OSTEOPOROSIS
- ☐ NO PROBLEMS

PULMONARY
- ☐ ASTHMA
- ☐ COPD / EMPHYSEMA
- ☐ NO PROBLEMS

RHEUMATOLOGY
- ☐ ARTHRITIS
- ☐ GOUT
- ☐ RHEUMATISM
- ☐ FIBROMYALGIA
- ☐ NO PROBLEMS

CANCER
TYPE

DATE

TREATMENT

ONCOLOGIST

☐ NO CANCER

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REVIEW OF SYMPTOMS

PLEASE CHECK ALL SYMPTOMS THAT YOU ARE **CURRENTLY** HAVING

GENERAL	CARDIOVASCULAR	MUSCULOSKELETAL
☐ CHILLS	☐ LEG PAIN WITH WALKING	☐ RECENT TRAUMA
☐ FATIGUE	☐ CHEST PAIN	☐ MUSCLE ACHES
☐ FEVER	☐ FLUID ACCUMULATION	☐ JOINT PAIN
☐ NIGHT SWEATS	☐ PALPITATIONS	☐ JOINT SWELLING
☐ WEIGHT GAIN	**GASTROINTESTINAL**	**SKIN**
☐ WEIGHT LOSS	☐ HERNIA	☐ DISCOLORATION
ALLERGY/IMMUNOLOGY	☐ ABDOMINAL PAIN	☐ ITCHING
☐ IMMUNE DEFICIENCY	☐ BLOOD IN STOOLS	☐ RASH
☐ ENVIRONMENTAL ALLERGIES	☐ CONSTIPATION	☐ CHANGE IN MOLES OR SPOTS
EYES	☐ DIARRHEA	**NEUROLOGICAL**
☐ BLURRY VISION	☐ HEARTBURN	☐ DIFFICULTY SPEAKING
☐ EYE PAIN	☐ NAUSEA	☐ FAINTING
EARS, NOSE, MOUTH	☐ VOMITING	☐ HEADACHE
☐ RUNNY NOSE	**HEMATOLOGY/ONCOLOGY**	☐ LOSS OF STRENGTH
☐ CONGESTION	☐ FREQUENT INFECTIONS	☐ MEMORY LOSS
☐ DIFFICULTY SWALLOWING	☐ EASY BRUISING	☐ TINGLING/NUMBNESS
☐ EAR PAIN	☐ EASY BLEEDING	☐ TREMOR/SHAKE
☐ RINGING IN EARS	**REPRODUCTIVE - FEMALE**	**PSYCHOLOGICAL**
☐ SORE THROAT	☐ PELVIC PAIN	☐ ANXIETY
ENDOCRINE	☐ MENOPAUSE SYMPTOMS	☐ DEPRESSION
☐ INCREASED HUNGER	☐ ABNORMAL PERIODS	☐ DIFFICULTY SLEEPING
☐ HAIR LOSS	☐ GENITAL SORES	☐ PHYSICAL OR MENTAL ABUSE
☐ COLD INTOLERANCE	☐ VAGINAL DISCHARGE	**OTHER PROBLEMS (brief discription)**
☐ EXCESSIVE THIRST	**REPRODUCTIVE - MALE**	
☐ HEAT INTOLERANCE	☐ ERECTILE DYSFUNCTION	
RESPIRATORY	☐ TESTICULAR PAIN	
☐ SHORTNESS OF BREATH	☐ PENILE DISCHARGE	
☐ COUGH	☐ GENITAL SORES	
☐ WHEEZING	**URINARY**	
☐ SNORING	☐ BLOOD IN URINE	
BREAST	☐ DIFFICULTY URINATING	
☐ BREAST LUMP	☐ KIDNEY STONES	**NO PROBLEMS**
☐ BREAST PAIN	☐ BLADDER/KIDNEY INFECTIONS	☐ I AM HAVING NO PROBLEMS TODAY
☐ NIPPLE DISCHARGE		
☐ BREAST SKIN CHANGES		

FAMILY HISTORY

LIST ALL HEALTH PROBLEMS KNOWN. IF DECEASED, LIST AGE AT DEATH

MOTHER	FATHER
SIBLINGS	CHILDREN
GRANDPARENTS	AUNT/UNCLE
OTHER	
☐ CHECK IF YOU ARE ADOPTED AND FAMILY HISTORY IS UNKNOWN	

SOCIAL HISTORY

☐ SMOKER PACKS PER DAY:	☐ SNUFF/CHEW CANS PER DAY:	☐ ALCOHOL DRINKS PER WEEK:
☐ ECIGARETTE/VAPOR	☐ STREET DRUGS	

PATIENT/GUARDIAN SIGNATURE	DATE
PSHC PROVIDER SIGNATURE	DATE