

# New Patient Health History Form (Adult)



| REASON FOR VISIT  |                             |                  | TODAY'S DATE       |                   |
|---|-----------------------------|------------------|--------------------|-------------------|
| LAST NAME   |                             | FIRST            | DATE OF BIRTH      | AGE               |
| MARITAL STATUS  | MARRIED                     | SINGLE           | DIVORCED           | WIDOWED/WIDOWERED |
| 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  | EENT                        | ENDOCRINE        |                    |                   |
| HIGH BLOOD PRESSURE   | CATARACT                    | THYROID DISEASE: | HYPO               | HYPER             |
| HEART ATTACK  | GLAUCOMA                    | DIABETES         |                    |                   |
| HIGH CHOLESTEROL  | VISION PROBLEM              | OSTEOPOROSIS     |                    |                   |
| HEART DISEASE<br>DESCRIBE:                                      | HEARING PROBLEM             | NO PROBLEMS      |                    |                   |
| NO PROBLEMS   | SINUSITIS / ALLERGIES       | PULMONARY        |                    |                   |
|   | DENTURES / IMPLANTS         | ASTHMA           |                    |                   |
| GASTROINTESTINAL  | NO PROBLEMS                 | COPD / EMPHYSEMA |                    |                   |
| ACID REFLUX, GERD   | INFECTIOUS DISEASE          | NO PROBLEMS      |                    |                   |
| DIVERTICULOSIS  | HISTORY OF CHICKEN POX      | RHEUMATOLOGY     |                    |                   |
| COLON POLYPS  | HISTORY OF TUBERCULOSIS     | ARTHRITIS        |                    |                   |
| HEMORRHOIDS   | HIV                         | GOUT             |                    |                   |
| LIVER DISEASE<br>DESCRIBE:                                      | HEPATITIS: A B C            | RHEUMATISM       |                    |                   |
| IRRITABLE BOWEL   | NO PROBLEMS                 | FIBROMYALGIA     |                    |                   |
|   | NEUROPSYCHIATRIC            | NO PROBLEMS      |                    |                   |
| HERNIA<br>DESCRIBE:   | ANXIETY                     | CANCER           |                    |                   |
| BOWEL DISEASE<br>DESCRIBE:                                      | DEPRESSION                  | TYPE             |                    |                   |
| NO PROBLEMS   | MOOD DISORDER:<br>DESCRIBE: | DATE             |                    |                   |
|   | SEIZURES                    | TREATMENT        |                    |                   |
| GENITOURINARY   | MEMORY PROBLEM              | ONCOLOGIST       |                    |                   |
| URINARY INCONTINENCE  | MIGRAINE                    |                  |                    |                   |
| PROSTATE ENLARGEMENT  | NEUROPATHY                  |                  |                    |                   |
| GYNECOLOGICAL DISEASE<br>(uterus, cervix, ovaries)<br>DESCRIBE: | STROKE                      |                  |                    |                   |
|   | NO PROBLEMS                 | NO CANCER        |                    |                   |
|   | OTHER PROBLEMS NOT LISTED   |                  |                    |                   |
| STD<br>DESCRIBE:  |                             |                  |                    |                   |
| KIDNEY DISEASE<br>DESCRIBE:                                     |                             |                  |                    |                   |
| NO PROBLEMS   |                             |                  |                    |                   |

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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             |                                    |
| BREAST PAIN  | BLADDER/KIDNEY INFECTIONS |                                    |
| NIPPLE DISCHARGE   |                           | <b>NO PROBLEMS</b>                 |
| BREAST SKIN CHANGES  |                           | I AM HAVING NO PROBLEMS TODAY      |
| 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   | SNUFF/CHEW                | ALCOHOL                            |
| PACKS PER DAY:   | CANS PER DAY:             | DRINKS PER WEEK:                   |
| ECIGARETTE/VAPOR   | STREET DRUGS              |                                    |
| PATIENT/GUARDIAN SIGNATURE                                     |                           | DATE                               |
| PSHC PROVIDER SIGNATURE  |                           | DATE                               |