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	EENT	ENDOCRINE
☐ HIGH BLOOD PRESSURE	☐ CATARACT	☐ THYROID DISEASE: ☐ HYPO ☐ HYPER
☐ HEART ATTACK	☐ GLAUCOMA	☐ DIABETES
☐ HIGH CHOLESTEROL	☐ VISION PROBLEM	☐ OSTEOPOROSIS
☐ HEART DISEASE	☐ HEARING PROBLEM	☐ NO PROBLEMS
DESCRIBE:	☐ SINUSITIS / ALLERGIES	**PULMONARY**
☐ NO PROBLEMS	☐ 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	☐ HEPATITIS: ☐ A ☐ B ☐ C	☐ RHEUMATISM
DESCRIBE:	☐ NO PROBLEMS	☐ FIBROMYALGIA
☐ IRRITABLE BOWEL	**NEUROPSYCHIATRIC**	☐ NO PROBLEMS
☐ HERNIA	☐ ANXIETY	**CANCER**
DESCRIBE:	☐ DEPRESSION	TYPE
☐ BOWEL DISEASE	☐ MOOD DISORDER:	
DESCRIBE:	DESCRIBE:	DATE
☐ NO PROBLEMS	☐ SEIZURES	
GENITOURINARY	☐ MEMORY PROBLEM	TREATMENT
☐ URINARY INCONTINENCE	☐ MIGRAINE	
☐ PROSTATE ENLARGEMENT	☐ NEUROPATHY	ONCOLOGIST
☐ GYNECOLOGICAL DISEASE	☐ STROKE	
(uterus, cervix, ovaries)	☐ NO PROBLEMS	☐ NO CANCER
DESCRIBE:	**OTHER PROBLEMS NOT LISTED**	
☐ STD		
DESCRIBE:		
☐ KIDNEY DISEASE		
DESCRIBE:		
☐ NO PROBLEMS		

New Patient Health History Form
(Adult)

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