PHYSICIANS' CLINIC
of Iowa, P.C.

HEALTH HISTORY FORM

Today's Date _____ First Name _____ Middle Initial_____ Last Name _____

Nickname _____ Date of Birth _____ Gender: ☐ Male ☐ Female

Family Physician _____ Referring Physician _____

Hospital Preference: ☐ Mercy Medical Center (Cedar Rapids) ☐ St. Luke's Hospital

Do you have an advanced directive? ☐ Yes ☐ No If yes, who is your surrogate decision maker? _____

MEDICATIONS: List all medications you have been taking. Please include over the counter and any supplements; list dosages and frequency.

Name of Medication (☐ See attached list for additional medications)	Dose	Frequency

ALLERGIES: Please list any allergies (☐ See attached list for additional allergies)

Drug	Describe Reaction	Other *(seasonal, food, etc.)*	Describe Reaction

Do you have sensitivity to Latex? ☐ Yes ☐ No Describe Reaction: _____

Please check any previous surgeries/hospitalizations and list the date/place they occurred:

☐ Appendix _____
☐ Bladder _____
☐ Cataract _____
☐ Child Birth _____
☐ Colon _____
☐ Ear _____
☐ Gallbladder _____
☐ Heart _____
☐ Hernia Repair _____
☐ Hysterectomy _____
☐ Joint Replacement _____
☐ Kidney _____
☐ Lung _____
☐ Nasal/Sinus _____
☐ Neck _____
☐ Oophorectomy _____
☐ Prostate _____
☐ Testicle _____
☐ Throat _____
☐ Tonsillectomy _____
☐ Urinary Stone _____
☐ Vasectomy _____
☐ Other (please describe) _____

PAST HEALTH HISTORY: *(Check all that apply)*

☐ Arthritis
☐ Blood Clots
☐ Cancer/Type _____
☐ Depression/Psychiatric Disorders
☐ Diabetes Mellitus
☐ Eye Conditions
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol or Lipids
☐ Kidney Disease
☐ Liver Disease/Hepatitis
☐ Lung Disease/Asthma
☐ MRSA/VRE
☐ Obstructive Sleep Apnea
☐ Received Blood in Past
☐ Stomach/Intestinal Problems
☐ Stroke
☐ Thyroid Disorder
☐ Tuberculosis
☐ Ulcers

Other Medical Conditions (please list): _____

SOCIAL HISTORY:

Occupation:
_____
☐ Retired
☐ Currently on Disability
☐ Working Full Time
☐ Working Part Time
☐ Unemployed
☐ Student

Marital Status:
☐ Single
☐ Currently Married/Partnered
☐ Divorced
☐ Widowed
Spouse/Partner Name:
_____

Alcohol/Drug Use:
Do you use alcohol? ☐ Yes ☐ No
How many drinks per week? _____
Have you used drugs for non-medicinal purposes? ☐ Yes ☐ No
If yes, ☐ Current ☐ Past

Tobacco Use:
☐ Current Smoker
How much/how long? _____
☐ Chewing Tobacco
☐ Former Smoker/Date Quit _____
☐ Never Smoked

Please continue to the back side⟶

FAMILY HISTORY: Has any member of your immediate family (father/mother/brother/sister/son/daughter) ever had the following conditions. If yes, indicate family member.

		Family Member			Family Member
☐ Yes ☐ No	Arthritis		☐ Yes ☐ No	High Blood Pressure	
☐ Yes ☐ No	Cancer (include type)		☐ Yes ☐ No	Kidney Disease	
☐ Yes ☐ No	Diabetes Mellitus		☐ Yes ☐ No	Lung Disease (COPD)	
☐ Yes ☐ No	Eye Conditions		☐ Yes ☐ No	Stroke	
☐ Yes ☐ No	Heart Disease		☐ Yes ☐ No	Stomach/Intestinal Problems	
☐ Yes ☐ No	High Cholesterol/Lipids		☐ Yes ☐ No	Ulcers	
☐ Yes ☐ No	Liver Disease/Hepatitis				

☐ Unable to obtain family history due to adoption or other circumstances.

Patient/Parent Signature: _____

Date: _____