



HEALTH HISTORY FORM

Today's Date _____ First Name _____ Last Name _____

Nickname _____ Date of Birth _____ Age _____ Gender: Male Female Pregnant? Yes No

Height (feet/inches) _____ Weight (pounds) _____ I request a chaperone during today's visit: Yes No

Family Physician _____ Referring Physician _____ Specialist _____

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

Reason for today's appointment (symptoms, onset, duration) _____

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

Recent tests or x-rays (when and where) _____

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

Name of Medication (<input type="checkbox"/> See attached list for additional medications.)	Dose	Frequency

ALLERGIES: Please list any 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 you have had:

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

PAST HOSPITALIZATION, SURGERIES, OR INJURIES:

Hospitalization for:	When:	Where:

PAST HEALTH HISTORY: (Check all that apply)

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

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: _____

Diet & Caffeine Use:

Do you use caffeine? Yes No
How much? _____
Daily fruit/vegetable intake? _____

Please continue to the back side —>

SOCIAL HISTORY (continued):

Exercise Habits:

- Exercise Regularly
Type/frequency? _____
- Exercise Occasionally
- Exercise Rarely
- Do Not Exercise

Alcohol/Drug Use:

- Do you use alcohol? Yes No
- How many drinks per week? _____
- Have you used drugs for non-medical purposes? Yes No

Tobacco Use:

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

FAMILY HISTORY: Has any member of your family (not to include spouse or in-laws) ever had the following conditions. If yes, indicate family member.

<u>Family Member</u>	<u>Family Member</u>
<input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer (include type) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes Mellitus _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Eye Conditions _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Lung Disease (COPD) _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Stroke _____
<input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol/Lipids _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Stomach/Intestinal Problems _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers _____

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

Please share the following information regarding your immediate family (i.e. father, mother, children, brothers, and sisters.)

Family Member	Alive/Year Born	Deceased/Age at Death	Cause of Death
Father			
Mother			

REVIEW OF SYSTEMS: Please check all symptoms you have experienced in the last MONTH.

Constitutional/General

- Fever
- Chills
- Heavy Sweating/Night Sweats
- Loss of Appetite
- Sleep Disturbances
- Unexplained Weight Loss/Gain
- Other: _____

Eyes

- Blurry Vision
- Double Vision
- Wear Glasses
- Other: _____

Ear/Nose/Throat

- Sore Throat
- Mouth Sores
- Nasal Congestion/Sinus Issues
- Hearing Loss
- Other: _____

Respiratory

- Cough
- COPD
- Wheezing
- Recurrent Upper Respiratory Infections
- Shortness of Breath
- Other: _____

Cardiovascular

- Chest Pain or Discomfort
- Swelling of Feet, Ankles or Legs
- Irregular Heart Beat
- Heart Attack
- Heart Failure
- Palpitations
- Varicose Veins
- Other: _____

Gastrointestinal

- Abdominal Pain
- Nausea/Vomiting
- Indigestion or Heartburn
- Blood in Stools
- Change in Bowel Habits
- Rectal Bleeding
- Diarrhea
- Constipation
- Swallowing Difficulties
- Other: _____

Psychological

- Depression
- Anxiety
- Other: _____

Genitourinary

- Painful Urination
- Urinary Frequency
- Loss of Urinary Control (PQRS 48)
- Enlarged Prostate
- Difficulty Urinating
- Other: _____

Skin

- Skin Rash
- Itching
- Discoloration of the Skin
- Lumps or Masses
- Other: _____

Musculoskeletal

- Joint Pain
- Joint Swelling
- Back Pain
- Limitation of Motion
- Neck Pain
- Pain with Walking
- Other: _____

Endocrine

- Excessive Thirst or Fluid Intake
- Temperature Intolerance
- Feeling Tired (Fatigue)
- Hot Flashes
- Other: _____

Hematologic/Lymphatic

- Swollen Glands
- Blood Clotting Problem
- Easy Bruising
- Bleeding Tendencies
- Other: _____

Neurological

- Tremors
- Dizzy Spells
- Numbness or Tingling
- Headache
- Unsteady Gait
- Feeling Weak
- Convulsions/Seizure
- Other: _____

This Space is Intentionally Blank for Additional Comments:

Patient/Parent Signature: _____

Date: _____

Provider Signature: _____

Date: _____