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 ☐ Surgery Center Cedar Rapids

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:

☐ Yes ☐ No Appendix _____
☐ Yes ☐ No Bladder _____
☐ Yes ☐ No Cataract _____
☐ Yes ☐ No Child Birth _____
☐ Yes ☐ No Colon _____
☐ Yes ☐ No Ear _____
☐ Yes ☐ No Gallbladder _____
☐ Yes ☐ No Heart _____
☐ Yes ☐ No Hernia Repair _____
☐ Yes ☐ No Hysterectomy _____
☐ Yes ☐ No Joint Replacement _____
☐ Yes ☐ No Kidney _____
☐ Yes ☐ No Lung _____
☐ Yes ☐ No Nasal/Sinus _____
☐ Yes ☐ No Neck _____
☐ Yes ☐ No Oophorectomy _____
☐ Yes ☐ No Prostate _____
☐ Yes ☐ No Testicle _____
☐ Yes ☐ No Throat _____
☐ Yes ☐ No Tonsillectomy _____
☐ Yes ☐ No Urinary Stone _____
☐ Yes ☐ No Vasectomy _____
☐ Other (please describe) _____

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

☐ Yes ☐ No Arthritis
☐ Yes ☐ No Blood Clots
☐ Yes ☐ No Cancer/Type _____
☐ Yes ☐ No Depression/Psychiatric Disorders
☐ Yes ☐ No Diabetes Mellitus
☐ Yes ☐ No Eye Conditions
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No High Cholesterol or Lipids
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Liver Disease/Hepatitis
☐ Yes ☐ No Lung Disease/Asthma
☐ Yes ☐ No MRSA/VRE
☐ Yes ☐ No Obstructive Sleep Apnea
☐ Yes ☐ No Received Blood in Past
☐ Yes ☐ No Stomach/Intestinal Problems
☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Disorder
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Ulcers

Other Medical Conditions (please list): _____

_____

Please continue to the back side ⟶

SOCIAL HISTORY:

Occupation: _____ ☐ Working Full Time ☐ Working Part Time

☐ Retired ☐ Currently Disabled ☐ Unemployed ☐ Student

Marital Status:

☐ Single

☐ Currently Married/Partnered Spouse/Partner Name: _____

☐ Divorced

☐ Widowed

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:

☐ Yes ☐ No Current Smoker How much/how long? _____

☐ Yes ☐ No Former Smoker/Date Quit _____

☐ Yes ☐ No Chewing Tobacco

☐ Yes ☐ No Vaping

☐ Yes ☐ No Never Smoked

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: _____

This form is destroyed after the information is entered and verified in the patient's electronic health record.