



# 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 ( <input type="checkbox"/> 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:

- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Appendix _____          | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney _____        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bladder _____           | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung _____          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cataract _____          | <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal/Sinus _____   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Child Birth _____       | <input type="checkbox"/> Yes <input type="checkbox"/> No Neck _____          |
| <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section              | <input type="checkbox"/> Yes <input type="checkbox"/> No Oophorectomy _____  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Colon _____             | <input type="checkbox"/> Yes <input type="checkbox"/> No Prostate _____      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ear _____               | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach _____       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Gallbladder _____       | <input type="checkbox"/> Yes <input type="checkbox"/> No Testicle _____      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart _____             | <input type="checkbox"/> Yes <input type="checkbox"/> No Throat _____        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia Repair _____     | <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillectomy _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hysterectomy _____      | <input type="checkbox"/> Yes <input type="checkbox"/> No Urinary Stone _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Replacement _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Vasectomy _____     |
| <input type="checkbox"/> Other (please describe) _____                           |  |

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis                        | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure        | <input type="checkbox"/> Yes <input type="checkbox"/> No Received Blood in Past      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Clots                      | <input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol or Lipids | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach/Intestinal Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer/Type _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Complications with Anesthesia    | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease/Hepatitis    | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disorder            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression/Psychiatric Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung Disease/Asthma        | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes Mellitus                | <input type="checkbox"/> Yes <input type="checkbox"/> No Malignant Hyperthermia     | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Eye Conditions                   | <input type="checkbox"/> Yes <input type="checkbox"/> No MRSA/VRE                   |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Obstructive Sleep Apnea    |  |

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.*