



# 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 Breast _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal/Sinus _____               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cataract _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No Neck _____                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Child Birth _____<br><input type="checkbox"/> Vaginal <input type="checkbox"/> C-section | <input type="checkbox"/> Yes <input type="checkbox"/> No Oophorectomy/Hysterectomy _____ |
| <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/Abdominal _____         |
| <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 Joint Replacement _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No Urinary Stone _____             |
| <input type="checkbox"/> Other (please describe) _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No Vasectomy _____                 |

**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): \_\_\_\_\_

**SOCIAL HISTORY:**

**Occupation:** \_\_\_\_\_  
 Retired    Currently Disabled    Unemployed    Student

Working Full Time    Working Part Time

**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.

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