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 Breast ____
☐ Yes ☐ No Cataract ____
☐ Yes ☐ No Child Birth ____
☐ Vaginal ☐ C-section
☐ Yes ☐ No Colon ____
☐ Yes ☐ No Ear ____
☐ Yes ☐ No Gallbladder ____
☐ Yes ☐ No Heart ____
☐ Yes ☐ No Hernia Repair ____
☐ Yes ☐ No Joint Replacement _______________________________________

☐ Yes ☐ No Kidney ____
☐ Yes ☐ No Lung ____
☐ Yes ☐ No Nasal/Sinus ____
☐ Yes ☐ No Neck ____
☐ Yes ☐ No Oophorectomy/Hysterectomy ______________________________
☐ Yes ☐ No Prostate ____
☐ Yes ☐ No Stomach/Abdominal ______________________________________
☐ 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 Complications with Anesthesia
☐ 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 Malignant Hyperthermia
☐ 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.