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| **FCHC Medical Group - PATIENT HEALTH HISTORY FORM**  **PLEASE COMPLETE IN BLACK INK** | | | | | | | | | | | | | | | | | | | | | | | | TODAY’S DATE PAGE 1 | | | | | | | | | | |
| LAST NAME | | | | | | | | | | LEGAL FIRST NAME | | | | | | | | | | | | | | MI | | | | | | DATE OF BIRTH | | | | |
| **YOUR HEALTH HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Check all items either**  **No or Yes** | **No** | | | **Yes, Now** | | | **Yes, Past** | | | **Check all items either**  **No or Yes** | | | | | | | | | | **No** | **Yes, Now** | **Yes, Past** | | **Check all items either**  **No or Yes** | | | | | | | **No** | | **Yes, Now** | **Yes, Past** |
| **CARDIOVASCULAR** | | | | | | | | | | **EYES** | | | | | | | | | | | | | | **INTEGUMENTARY/SKIN** | | | | | | | | | | |
| Drug Allergies |  | | |  | | |  | | | Blurred Vision | | | | | | | | | |  |  |  | | Boils/Lesions | | | | | | |  | |  |  |
| Hay Fever |  | | |  | | |  | | | Double Vision | | | | | | | | | |  |  |  | | Persistent Itch | | | | | | |  | |  |  |
| Latex Allergy |  | | |  | | |  | | | Eye Pain | | | | | | | | | |  |  |  | | Skin Rash | | | | | | |  | |  |  |
| High Blood Pressure |  | | |  | | |  | | | Failing Vision | | | | | | | | | |  |  |  | | **MUSCULOSKELETAL** | | | | | | | | | | |
| Low Blood Pressure |  | | |  | | |  | | | Vision Loss | | | | | | | | | |  |  |  | | Back Pain | | | | | | |  | |  |  |
| Palpitations |  | | |  | | |  | | | **GASTROINTESTINAL** | | | | | | | | | | | | | | History of Falls | | | | | | |  | |  |  |
| Varicose Veins |  | | |  | | |  | | | Abdominal Pain | | | | | | | | | |  |  |  | | History of Fractures | | | | | | |  | |  |  |
| **CONSTITUTIONAL** | | | | | | | | | | Appetite Loss | | | | | | | | | |  |  |  | | Joint Pain | | | | | | |  | |  |  |
| Chills |  | | |  | | |  | | | Blood in Stool | | | | | | | | | |  |  |  | | Neck Pain | | | | | | |  | |  |  |
| Fatigue or Weakness |  | | |  | | |  | | | Constipation | | | | | | | | | |  |  |  | | **NEUROLOGICAL** | | | | | | | | | | |
| Fever |  | | |  | | |  | | | Diarrhea | | | | | | | | | |  |  |  | | Dizzy Spells | | | | | | |  | |  |  |
| Headache (Frequent) |  | | |  | | |  | | | GI Bleed | | | | | | | | | |  |  |  | | Memory Loss | | | | | | |  | |  |  |
| Weight Gain |  | | |  | | |  | | | Indigestion/Heartburn | | | | | | | | | |  |  |  | | Numbness/Tingling | | | | | | |  | |  |  |
| Weight Loss |  | | |  | | |  | | | Nausea/Vomiting | | | | | | | | | |  |  |  | | Seizures | | | | | | |  | |  |  |
| **EAR/NOSE/THROAT** | | | | | | | | | | Ulcers/Reflux/GERD | | | | | | | | | |  |  |  | | Stroke | | | | | | |  | |  |  |
| Difficulty Hearing |  | | |  | | |  | | | **GENITOURINARY** | | | | | | | | | | | | | | Tremors | | | | | | |  | |  |  |
| Ear Infections |  | | |  | | |  | | | Bladder Leakage | | | | | | | | | |  |  |  | | **PSYCHIATRIC** | | | | | | | | | | |
| Ringing Ears |  | | |  | | |  | | | Blood in Urine | | | | | | | | | |  |  |  | | Anxiety | | | | | | |  | |  |  |
| Sinus Trouble |  | | |  | | |  | | | Painful Urination | | | | | | | | | |  |  |  | | Depression | | | | | | |  | |  |  |
| Sore Throat |  | | |  | | |  | | | Urinary Frequency | | | | | | | | | |  |  |  | | Difficulty Sleeping | | | | | | |  | |  |  |
| **ENDOCRINE** | | | | | | | | | | Urine Retention | | | | | | | | | |  |  |  | | **RESPIRATORY** | | | | | | | | | | |
| Cold Intolerance |  | | |  | | |  | | | **HEMATOLOGIC/LYMPHATIC** | | | | | | | | | | | | | | Difficulty Breathing | | | | | | |  | |  |  |
| Excessive Thirst |  | | |  | | |  | | | Abnormal Bleeding | | | | | | | | | |  |  |  | | Frequent Cough | | | | | | |  | |  |  |
| Heat Intolerance |  | | |  | | |  | | | Bleeding Disorders | | | | | | | | | |  |  |  | | History/Exposure TB | | | | | | |  | |  |  |
| Thyroid Trouble |  | | |  | | |  | | | Blood Clotting Problems | | | | | | | | | |  |  |  | | Shortness of Breath | | | | | | |  | |  |  |
| Tired/Sluggish |  | | |  | | |  | | | Swollen Glands | | | | | | | | | |  |  |  | | Wheezing | | | | | | |  | |  |  |
| **HABITS/SOCIAL HISTORY** | | | | | | | | | | | | | | | | | | | **MEDICATIONS** | | | | | | | | | | | | | | | |
| **Do you:** | | **No** | | | | **Yes** | | | | **If Yes, how much?** | | | | | | | | | Please list all medications you are now taking, including those you buy without a doctor’s prescription (over-the-counter, supplements, herbals, etc.) | | | | | | | | | | | | | | | |
| Smoke Tobacco | |  | | | |  | | | | Packs/Day | | | | | | | | |
| Chew Tobacco | |  | | | |  | | | | Tins or Bags/Day | | | | | | | | |
| **Did you Smoke?** | |  | | | |  | | | | Year Quit | | | | | | | | | **What pharmacy do you use?** | | | | | | | | | |  | | | | | |
| How many years did you smoke? | | | | | | | | | | Packs/Day | | | | | | | | | **Medication** | | | | | | | **Dosage** | | | **How many times a day?** | | | | | |
| Drink Alcohol or Wine | |  | | | |  | | | | Drinks/Day | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| Drink Beer | |  | | | |  | | | | Cans/Day | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| Drink Caffeine | |  | | | |  | | | | Cups/Day | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| Use Recreational Drugs | |  | | | |  | | | |  | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| Exercise | |  | | | |  | | | |  | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| Live Alone | |  | | | |  | | | |  | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| History of Falls | |  | | | |  | | | |  | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| History of Fractures | |  | | | |  | | | |  | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| **IMMUNIZATIONS** | | | | | | | | | | | | | | | | | | | **ALLERGIES** | | | | | | | | | | | | | | | |
|  | | **No** | | | | **Yes** | | | | **Date** | | | | | | | | |  | | | | **No** | | | **Yes** | | **Reaction** | | | | | | |
| Flu Shot | |  | | | |  | | | |  | | | | | | | | | Aspirin | | | |  | | |  | |  | | | | | | |
| Hepatitis B | |  | | | |  | | | |  | | | | | | | | | Banana | | | |  | | |  | |  | | | | | | |
| MMR | |  | | | |  | | | |  | | | | | | | | | Bee Sting | | | |  | | |  | |  | | | | | | |
| Pertussis (Whooping Cough) | |  | | | |  | | | |  | | | | | | | | | Codeine | | | |  | | |  | |  | | | | | | |
| Drug | | | |  | | |  | |  | | | | | | |
| Pneumonia | |  | | | |  | | | |  | | | | | | | | | Hay Fever | | | |  | | |  | |  | | | | | | |
| Tetanus | |  | | | |  | | | |  | | | | | | | | | Latex | | | |  | | |  | |  | | | | | | |
| Zoster (Shingles) | |  | | | |  | | | |  | | | | | | | | | Peanuts | | | |  | | |  | |  | | | | | | |
| **SPIRITUAL/RELIGIOUS PRACTICES** | | | | | | | | | | | | | | | | | | | Penicillin | | | |  | | |  | |  | | | | | | |
|  | | **No** | | | | **Yes** | | | | **Explanation** | | | | | | | | | Shellfish | | | |  | | |  | |  | | | | | | |
| Are there any spiritual/ religious practices or restrictions we should know about in providing your medical care? | |  | | | |  | | | |  | | | | | | | | | Sulfa | | | |  | | |  | |  | | | | | | |
|  | | | | | | | | | Other | | | |  | | |  | |  | | | | | | |
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| **FCHC Medical Group - PATIENT HEALTH HISTORY FORM**  **PLEASE COMPLETE IN BLACK INK** | | | | | | | | | | | | | | | | | | | | | | | | TODAY’S DATE PAGE 2 | | | | | | | | | | |
| LAST NAME | | | | | | | | | | | LEGAL FIRST NAME | | | | | | | | | | | | | MI | | | | | | DATE OF BIRTH | | | | |
| **Are you being treated by other Healthcare Professionals?** No Yes **If yes, please list doctors & reasons for treatment.**  Physician/Specialist  Dentist  Chiropractor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HOSPITALIZATIONS**  **(NOT INCLUDING NORMAL PREGNANCIES)** | | | | | | | | | | | | | | | | | | | **SERIOUS ILLNESS**  **(NOT REQUIRING HOSPITALIZATION)** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | Year | | | | | |  | | | | | | | | | | | | | Year | | |
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| **PAST SURGERIES** | | | | | | | | | | | | | | | | | | | **PAST ACCIDENTS** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | Year | | | | | |  | | | | | | | | | | | | | Year | | |
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| **FAMILY HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | **Living** | | **Deceased** | | Year of Birth | | Age | | | Hypertension | | Diabetes | Heart Disease | Stroke | | Mental Illness | Cancer: List Type | | | | | | | | Other Health Issue: List | | | | | | | |
| Father | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Mother | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Father’s Grandfather | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Father’s Grandmother | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Mother’s Grandfather | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Mother’s Grandmother | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Son(s) | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Daughter(s) | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Siblings: | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
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| Spouse | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| **OTHER INFORMATION** | | | | | | | | | | | | | | | | | | | **WOMEN ONLY** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | **No** | | **Yes** | |  | | | | | | | | | | | | | | **No** | **Yes** |
| Last Colonoscopy? |  | | | | | | | Abnormal? | | | | | | |  | |  | | Last Pap Smear? | | | | | |  | | | | Abnormal? | | | |  |  |
| Last Sigmoidoscopy |  | | | | | | | Abnormal? | | | | | | |  | |  | | Last Mammogram? | | | | | |  | | | | Abnormal? | | | |  |  |
| Last Hema-Chek? |  | | | | | | | Abnormal? | | | | | | |  | |  | | Age Periods Started? | | | | | |  | | | | Problems? | | | |  |  |
| Wake in the night to go to the bathroom? | | | | | | | | | | | | | | |  | |  | | Ovarian Cysts? | | | | | | | | | | | | | |  |  |
| Are you currently sexually active? | | | | | | | | | | | | | | |  | |  | | Vaginal itching, burning or discharge? | | | | | | | | | | | | | |  |  |
| Sexual Problems or concerns? | | | | | | | | | | | | | | |  | |  | | Breast lumps, disease or nipple discharge? | | | | | | | | | | | | | |  |  |
| Do you feel safe in your home? | | | | | | | | | | | | | | |  | |  | | Pregnant Now? | | | | | | | | | | | | | |  |  |
| Do you have a Living Will? | | | | | | | | | | | | | | |  | |  | | Planning a Pregnancy? | | | | | | | | | | | | | |  |  |
| If Yes, where is it? | | | | | | | | | | | | | | | | | | | Nursing a Child? | | | | | | | | | | | | | |  |  |
| If No, would you like information on Living Wills? | | | | | | | | | | | | | | |  | |  | | Pregnancies | | | | | | # | | | | Births | | | | # | |
| Have you ever been treated for alcohol abuse? | | | | | | | | | | | | | | |  | |  | | Miscarriages | | | | | | # | | | | Abortions | | | | # | |
| Have you ever been treated for drug abuse? | | | | | | | | | | | | | | |  | |  | | Birth Control Method | | | | | | | | | | | | | | | |
| Do you currently abuse any substances? | | | | | | | | | | | | | | |  | |  | |  | | | | | | | | | | | | | |  |  |
| Are you under a lot of pressure/stress at work? | | | | | | | | | | | | | | |  | |  | | **MEN ONLY** | | | | | | | | | | | | | | | |
| Are you under a lot of pressure/stress at home? | | | | | | | | | | | | | | |  | |  | |  | | | | | | | | | | | | | | **No** | **Yes** |
| Have you ever had anesthesia? | | | | | | | | | | | | | | |  | |  | | Last PSA? | | | | | |  | | | | Abnormal? | | | |  |  |
| If Yes, did you have any problems? | | | | | | | | | | | | | | | | | | | Last Prostate Exam? | | | | | |  | | | | Abnormal? | | | |  |  |
| Are you on a special diet? | | | | | | | | | | | | | | |  | |  | | Pain or lump(s) in testicles? | | | | | | | | | | | | | |  |  |
| Are you on any food restrictions? | | | | | | | | | | | | | | |  | |  | | Penile (penis) itching, burning or discharge? | | | | | | | | | | | | | |  |  |
| If Yes, specify | | | | | | | | | | | | | | | | | | | Prostate Disease or problems? | | | | | | | | | | | | | |  |  |
| Have you had a blood transfusion in the past 6 months? | | | | | | | | | | | | | | |  | |  | | Problems starting or stopping your urine stream? | | | | | | | | | | | | | |  |  |

The information on this Patient Health History Form is correct to the best of my knowledge.

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PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE REVIEWED BY PROVIDER DATE