partnership® HEALTH CENTERS

Patient History Form

DATE:

NAME: **DATE OF BIRTH:**

PAST MEDICAL HISTORY

CONDITION:	DATE:	CONDITION:	DATE :
□ Anemia	_____	□ Hemorrhoids	_____
□ Arthritis	_____	□ Hepatitis	_____
□ Asthma	_____	□ HIV	_____
□ Bleeding Problems	_____	□ Kidney disease: _____	_____
□ Blood Pressure/Hypertension	_____	□ Kidney failure	_____
□ Broken Bones: _____	_____	□ Kidney stones (left/right/both)	_____
□ Cancer (type: _____)	_____	□ Lung disease	_____
□ Chest Pain	_____	□ Mental Health issues _____	_____
□ Chronic Pain (area:_____)	_____	□ Migraines	_____
□ Cirrhosis, liver	_____	□ Osteoporosis	_____
□ COPD, emphysema	_____	□ Seizure disorder	_____
□ Diabetes: Type 1__ or Type 2 __	_____	□ Sinusitis, recurrent	_____
□ Dementia	_____	□ Skin disorder: _____	_____
□ Depression	_____	□ Stroke (deficit:_____)	_____
□ Ear Infections, recurrent	_____	□ Sexually transmitted diseases	_____
□ Enlarged heart	_____	□ Thyroid disorder: _____	_____
□ Glaucoma	_____	□ Urinary Symptoms	_____
□ Heartburn	_____	□ Venous Clots (DVT)	_____
□ Heart disease: _____	_____	□ Other: _____	_____
□ Heart failure (Echo? _____)	_____	□ Other:_____	_____
WOMEN ONLY:			
□ Menstrual problems/changes	_____	□ Abnormal pap	_____
□ Ovarian cysts	_____	□ Breast lump/pain	_____
MEN ONLY:			
□ Prostate issues	_____	□ Erectile dysfunction	_____

HOSPITALIZATIONS AND ER VISITS:

□ I have never been hospitalized □ I have not been to the ER

DATE: _____ HOSPITAL: _____ DIAGNOSIS: _____
DATE: _____ HOSPITAL: _____ DIAGNOSIS: _____
DATE: _____ HOSPITAL: _____ DIAGNOSIS: _____
DATE: _____ HOSPITAL: _____ DIAGNOSIS: _____
DATE: _____ HOSPITAL: _____ DIAGNOSIS: _____

SURGERIES

☐ I have never had surgery

DATE: _____ SURGERY: _____
DATE: _____ SURGERY: _____
DATE: _____ SURGERY: _____
DATE: _____ SURGERY: _____
DATE: _____ SURGERY: _____

MEDICATIONS

☐ I take no medications

MEDICATION	DOSE	# TIMES TAKEN/DAY	CONDITION

ALLERGIES

MEDICATIONS: ☐ I have no medication allergies

Medication	Reaction

FOOD: ☐ I have no food allergies

Food	Reaction

ENVIRONMENTAL EXPOSURES: ☐ I have no environmental allergies

Exposure	Reaction

IMMUNIZATIONS

Immunization:	Date:	Immunization:	Date:	Immunization:	Date:
□ Chicken pox	_____	□ Influenza	_____	□ Tdap or □ Td	_____
□ Gardasil (HPV)	_____	□ Meningitis	_____	□ Other:	_____
□ Hepatitis A	_____	□ MMR	_____	□ Other:	_____
□ Hepatitis B	_____	□ Pneumovax	_____	□ Prevnar (adult)	_____
□ Zostavax	_____				

FAMILY HISTORY

List any relatives who have the following conditions:

Diabetes _____ High blood Pressure_____
Heart attack_____ Breast cancer_____
Stroke_____ Colon cancer_____
Tuberculosis_____ High cholesterol_____
Alzheimer's_____ Melanoma_____
Prostate cancer_____ Ovarian Cancer_____
Celiac disease_____ Sickle cell/Thalassemia_____

LIFESTYLE HISTORY

Marital Status: □ Single □Married □Widowed □Divorced
□Significant other (male) □Significant Other (female)

Exercise:
How often? □ never □ 1-2 times/week □ 3-5 times/week □ nearly every day
How many average minutes each time: □ < 15 □ 15-30 □ 30-60 □ > 60
What exercise to you do? _____

Diet:
Do you drink caffeine? □ Yes □ No
If yes, how many cups/cans per day: □ 1-2 □ 3-4 □ 5-6 □ 7 or more
What do you drink? _____
Check any foods on the list that you AVOID:
□ Dairy □ Salt □ Sugar □ Gluten □ Meat □ Eggs □ Carbs □ Fats(oils) □ Other: _____
How often do you eat "fast food"?
□ Never □ Less than once a month □ Less than weekly □ Weekly □ > Once a week □ Daily

Are you sexually active? □ Yes □ No
Do you (or have you ever) used recreational drugs (cocaine, heroin, marijuana, etc…) □ Yes □ No
Do you have a lot of stress in your life? □ Yes □ No
Do you feel depressed? □ Yes □ No
Any travel outside of the U.S? □ Yes □ No If Yes, where and when? _____
_____
Any exposure to toxic chemicals or substance? □ Yes □ No What? _____
Current Occupation: _____

Review of Symptoms

Do you have any of the following currently or have had in the last 2 weeks: (check all that apply)

□ Change in appetite
□ Nausea/Vomiting
□ Change in bowels
□ Painful Urination
□ Testicular Pain or swelling
□ Breast pain or lump
□ Fevers/chills
□ Feeling faint or almost passing out
□ Constant sinus drainage
□ Trouble swallowing
□ Swollen legs
□ Joint swelling or pain
□ Mood swings
□ Headaches
□ Changes in hair or hair loss
□ Palpitations
□ Constipation
□ Blood in Stool
□ Weight loss
□ Frequent or urgent urination
□ Vaginal discharge and/or odor
□ Bruise or bleed easily
□ Swollen glands
□ Changes in vision
□ Chronic cough
□ Short of breath lying down
□ Trouble sleeping
□ Feeling too hot or too cold
□ Head injury
□ Tingling or numbness
□ Skin rash
□ Dizziness
□ Diarrhea
□ Abdominal Pain
□ Weight Gain
□ Blood in Urine
□ Nipple discharge
□ Night Sweats
□ General body aches
□ Frequent nosebleeds
□ Recurrent gum/tooth infections
□ Short of breath with exertion
□ Muscle weakness or pain
□ Memory loss
□ Loss of consciousness
□ Panic attacks or feeling anxious
□ Chest pain
□ Coughing up blood

Health Maintenance

Please provide dates for the following:
Last Physical: _____
Cholesterol Test: _____
Colonoscopy: _____ Normal? □ Yes □ No
EKG: _____
Bone Density: _____
Complete Blood Count: _____
Thyroid Test: _____
Chest X-ray: _____

Women Only:
Last Pap Smear: _____ Normal? □ Yes □ No
Last Mammogram: _____ Normal? □ Yes □ No
Pregnancies: _____
How many children do you have? _____
Last Menstrual Period _____

Men Only:
Prostate Exam: _____