Patient's Personal History and Health Assessment Date:

Patient Name:

DOB: ☐ Male ☐ Female | **Social Security Number:**

Patient Address:

City: **State:** **Zip Code:**

Primary Phone Number: **Other Phone #:**

Email Address:

Employer: **Employer Phone Number:**

Nearest Relative/Kin: **Relationship:**

Address:

Phone Number:

Date of Last Physician Visit: **Physician Name:**

DO YOU HAVE ANY FAMILY HISTORY OF:

	YES	NO	RELATIVE	ALIVE OR DECEASED (Or list other family history)
High Cholesterol	☐	☐		
High Blood Pressure	☐	☐		
Diabetes	☐	☐		
Cancer	☐	☐		
Heart Attack/Stroke	☐	☐		

SOCIAL HISTORY

	YES	NO	FREQUENCY (Amount of Intake)
Alcohol Use	☐	☐	
Tobacco Use	☐	☐	
Drink Coffee	☐	☐	

Do you exercise: ☐ Regularly ☐ Occasionally ☐ Rarely ☐ Never

Have you used any of the following: ☐ Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Other:

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated ☐ Live Alone

Preferred Language: ☐ English ☐ Spanish ☐ Other: **Religion:**

Race/Ethnicity: ☐ Asian ☐ African American ☐ Caucasian ☐ Latino ☐ Multiracial ☐ Other

How did you hear about us? ☐ Friend ☐ Family ☐ Co-Worker ☐ Physician ☐ Insurance Plan ☐ Other

DO YOU USE ANY OF THE FOLLOWING:

☐ Glasses	☐ Hearing Aids	☐ Cane	☐ Walker	☐ Wheelchair	☐ Oxygen	☐ Nebulizer	☐ Catheter

Immunizations:	☐ Pneumococcal	☐ Rubella	☐ Tetanus	☐ Influenza	☐ Diphtheria	☐ Other

Are you allergic to any medications? ☐ YES ☐ NO **If yes, please list:**

Do you take any medications currently? ☐ YES ☐ NO If yes, please list amount and frequency below

List of medications taken (includes over the counter, such as Tylenol or Vitamins)

OPERATIONS/SERIOUS INJURIES: List and indicate approximate year of operation and/or injuries:

HOSPITALIZATIONS (Other than the above operations, especially in the last year):

Check if you or a relative have or had any of the following illnesses. If unsure, leave blank:								
Alcohol Overuse	☐ Yes	☐ No	☐ Relative	**High Blood Pressure**	☐ Yes	☐ No	☐ Relative
Allergies	☐ Yes	☐ No	☐ Relative	**Heart Attack**	☐ Yes	☐ No	☐ Relative
Anemia	☐ Yes	☐ No	☐ Relative	**Intestinal Polyps**	☐ Yes	☐ No	☐ Relative
Arthritis	☐ Yes	☐ No	☐ Relative	**Jaundice**	☐ Yes	☐ No	☐ Relative
Asthma	☐ Yes	☐ No	☐ Relative	**Leukemia**	☐ Yes	☐ No	☐ Relative
Bleeding Tendency	☐ Yes	☐ No	☐ Relative	**Measles**	☐ Yes	☐ No	☐ Relative
Cancer	☐ Yes	☐ No	☐ Relative	**Migraine**	☐ Yes	☐ No	☐ Relative
Chicken Pox	☐ Yes	☐ No	☐ Relative	**Mumps**	☐ Yes	☐ No	☐ Relative
Congenital Heart Disease	☐ Yes	☐ No	☐ Relative	**Nervous Breakdown**	☐ Yes	☐ No	☐ Relative
Depression	☐ Yes	☐ No	☐ Relative	**Radiation Treatment**	☐ Yes	☐ No	☐ Relative
Diabetes	☐ Yes	☐ No	☐ Relative	**Rheumatic Fever**	☐ Yes	☐ No	☐ Relative
Dialysis	☐ Yes	☐ No	☐ Relative	**Sexually Transmitted Disease**	☐ Yes	☐ No	☐ Relative
Emphysema	☐ Yes	☐ No	☐ Relative	**Sickle Cell Anemia**	☐ Yes	☐ No	☐ Relative
Epilepsy	☐ Yes	☐ No	☐ Relative	**Stomach Ulcers**	☐ Yes	☐ No	☐ Relative
Kidney/Bladder Infections Often	☐ Yes	☐ No	☐ Relative	**Stroke**	☐ Yes	☐ No	☐ Relative
Lung Infections Often	☐ Yes	☐ No	☐ Relative	**Suicide Attempt**	☐ Yes	☐ No	☐ Relative
Gallbladder Disease	☐ Yes	☐ No	☐ Relative	**Thyroid**	☐ Yes	☐ No	☐ Relative
Goiter	☐ Yes	☐ No	☐ Relative	**Tuberculosis**	☐ Yes	☐ No	☐ Relative
Gout	☐ Yes	☐ No	☐ Relative	**Whooping Cough**	☐ Yes	☐ No	☐ Relative
Hay Fever	☐ Yes	☐ No	☐ Relative	**Other**	☐ Yes	☐ No	☐ Relative
Herpes	☐ Yes	☐ No	☐ Relative				

REVIEW OF SYSTEMS - GENERAL		
Do you usually feel persistently tired and worn out?	☐ Yes	☐ No
Have you recently been drinking more water or fluids?	☐ Yes	☐ No
Has there been any unusual weight gain or loss recently?	☐ Yes	☐ No
REVIEW OF SYSTEMS - CARDIOVASCULAR		
Do you have pain, tightness, or pressure in the front or back of your chest?	☐ Yes	☐ No
Have you been told your electrocardiogram was abnormal?	☐ Yes	☐ No
Do you have any swelling of your feet or ankles?	☐ Yes	☐ No
Does your heart ever beat fast or irregularly?	☐ Yes	☐ No
Do you have cramps in the calf muscles when you walk?	☐ Yes	☐ No
Do your fingers or toes ever get cold, become numb, or get white or bluish?	☐ Yes	☐ No
REVIEW OF SYSTEMS – CENTRAL NERVOUS SYSTEM		
Do you have frequent or severe headaches?	☐ Yes	☐ No
Do you often have spells of dizziness, faintness, or lightheadedness?	☐ Yes	☐ No
Do you sometimes lose the ability to speak?	☐ Yes	☐ No

Have you recently fainted, blacked out, or lost consciousness?	☐ Yes ☐ No
Do you have trouble remembering recent events?	☐ Yes ☐ No
Do you ever have convulsions or fits?	☐ Yes ☐ No
Have you ever wanted to commit suicide?	☐ Yes ☐ No
Do you ever hear voices or see people when no one is around?	☐ Yes ☐ No
In past 2 weeks, how often have you been bothered by any of the following problems: Little interest or pleasure in doing things ☐ Not at all ☐ Several Days ☐ More half the days ☐ Nearly Every Day Feeling down, depressed or hopeless ☐ Not at all ☐ Several Days ☐ More half the days ☐ Nearly Every Day	

REVIEW OF SYSTEMS – EYES and ENT (EARS, NOSE AND THROAT)			
Have you had any pain in your eyes?	☐ Yes ☐ No	Have you had bleeding gums?	☐ Yes ☐ No
Have you had Glaucoma?	☐ Yes ☐ No	Do you have persistent hoarseness?	☐ Yes ☐ No
Have you had blurry vision?	☐ Yes ☐ No	Do you have trouble hearing?	☐ Yes ☐ No
Have you had halo around lights?	☐ Yes ☐ No	Do you have ringing in ears?	☐ Yes ☐ No
Have you had change in vision?	☐ Yes ☐ No	Do you have earaches or discharge?	☐ Yes ☐ No
Have you had cataracts or implants?	☐ Yes ☐ No	Do you have drainage in back of throat?	☐ Yes ☐ No
Do you have frequent/severe nose bleeds? ☐ Yes ☐ No			

REVIEW OF SYSTEMS - GASTROINTESTINAL	
Have you recently had any changes in your eating habits?	☐ Yes ☐ No
Have you recently noted any trouble in swallowing?	☐ Yes ☐ No
Do you have a lot of indigestion or heartburn?	☐ Yes ☐ No
Have you vomited blood?	☐ Yes ☐ No
Are you bothered with constipation?	☐ Yes ☐ No
Do you have frequent loose stools or diarrhea?	☐ Yes ☐ No

REVIEW OF SYSTEMS – MUSCULOSKELETAL AND RESPIRATORY		
Do you ever have a problem with back pain? ☐ Yes ☐ No	Do you have wheezing in your chest?	☐ Yes ☐ No
Does back pain interfere with your daily life? ☐ Yes ☐ No	Do you have coughing or blood?	☐ Yes ☐ No
Do you have joint stiffness/pain (arthritis)? ☐ Yes ☐ No	Do you have constant or bothersome cough?	☐ Yes ☐ No
Do you have trouble walking, using hips, or knee joints? ☐ Yes ☐ No	Do you have frequent chest colds or pneumonia?	☐ Yes ☐ No
Do you have difficulty breathing? ☐ Yes ☐ No		

REVIEW OF SYSTEMS - GENITOURINARY	
Do you have burning or pain when you urinate?	☐ Yes ☐ No
Do you have to pass water frequently?	☐ Yes ☐ No
Do you have to get up at night?	☐ Yes ☐ No
Do you trouble with losing urine when you cough or sneeze?	☐ Yes ☐ No
Do you have a problem with dribbling urine?	☐ Yes ☐ No
Have you had an operation to prevent pregnancy (ex. Vasectomy, tube ligation)?	☐ Yes ☐ No
Do you have prostate gland trouble?	☐ Yes ☐ No
Do you have a problem using the toilet (for urination or bowl movement)?	☐ Yes ☐ No

REVIEW OF SYSTEMS - SKIN	
Do you have any change in the color of your skin?	☐ Yes ☐ No
Do you have any rashes or itching?	☐ Yes ☐ No
Do you have any growths or lumps on your skin?	☐ Yes ☐ No
Do you have any sores or wounds that do not heal?	☐ Yes ☐ No
Have you had any change in the color or size of warts or moles?	☐ Yes ☐ No

ACTIVITIES OF DAILY LIVING:			
Are you sexually active? If yes, please check sexual preference below ☐ Partner same sex ☐ Partner opposite sex ☐ Partner of both sexes			☐ Yes ☐ No
Do you consistently use contraceptives?			☐ Yes ☐ No
Do you drive? If no, who aids in transportation needs ☐ a friend and/or relative ☐ Public transportation			☐ Yes ☐ No
Do you own your home?	☐ Yes ☐ No	Do you rent your home?	☐ Yes ☐ No
Do you live alone?	☐ Yes ☐ No	Do you have a Will?	☐ Yes ☐ No
Do you have a Living Will?	☐ Yes ☐ No	Do you need legal assistance?	☐ Yes ☐ No
Are you presently employed?	☐ Yes ☐ No	Are you retired?	☐ Yes ☐ No
Does or did your work involve work exposure to dust, noise, radioactivity, etc.?			☐ Yes ☐ No
Do you have any work limitations due to any disability?			☐ Yes ☐ No
Have you recently lived or traveled outside the United States?			☐ Yes ☐ No
Do you eat less than 3 meals a day?			☐ Yes ☐ No
Do you have special food customs or restrictions?			☐ Yes ☐ No
Do you use any community services (VNA, Meals on Wheels, transportation? If yes, please list:			☐ Yes ☐ No
WOMEN ONLY:			
Did you have any pregnancies? If yes, please indicate how many			☐ Yes ☐ No
Have you had any lumps in your breasts?			☐ Yes ☐ No
Have you had any abnormal bleeding from the vagina in the past year?			☐ Yes ☐ No
Have you passed the menopause or change?			☐ Yes ☐ No
Do you have any prolapse (“falling out”) of the vagina or uterus?			☐ Yes ☐ No
Have you had a hysterectomy?			☐ Yes ☐ No
Do you have any vaginal discharge?			☐ Yes ☐ No

PREFERRED PHARMACY (NAME AND ADDRESS)?

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?