FCHC Medical Care - PATIENT HEALTH HISTORY FORM

PLEASE COMPLETE IN BLACK INK

TODAY'S DATE

LAST NAME	LEGAL FIRST NAME	MI	DATE OF BIRTH

YOUR HEALTH HISTORY

Check all items either No or Yes	No	Yes, Now	Yes, Past
ALLERGY			
Drug Allergies			
Hay Fever			
Latex Allergy			
CARDIOVASCULAR			
Chest Pain			
Heart Defects			
Heart Murmur			
High Blood Pressure			
Low Blood Pressure			
Palpitations			
Varicose Veins			
CONSTITUTIONAL			
Chills			
Fatigue or Weakness			
Fever			
Headache (Frequent)			
Weight Gain			
Weight Loss			
EAR/NOSE/THROAT			
Difficulty Hearing			
Ear Infections			
Ringing Ears			
Sinus Trouble			
Sore Throat			
ENDOCRINE			
Cold Intolerance			
Excessive Thirst			
Heat Intolerance			
Thyroid Trouble			
Tired/Sluggish			

Check all items either No or Yes	No	Yes, Now	Yes, Past
EYES			
Blurred Vision			
Double Vision			
Eye Pain			
Failing Vision			
Vision Loss			
GASTROINTESTINAL			
Abdominal Pain			
Appetite Loss			
Blood in Stool			
Constipation			
Diarrhea			
GI Bleed			
Indigestion/Heartburn			
Nausea/Vomiting			
Ulcers/Reflux/GERD			
GENITOURINARY			
Bladder Leakage			
Blood in Urine			
Painful Urination			
Urinary Frequency			
Urine Retention			
HEMATOLOGIC/LYMPHATIC			
Abnormal Bleeding			
Bleeding Disorders			
Blood Clotting Problems			
Swollen Glands			

Check all items either No or Yes	No	Yes, Now	Yes, Past
INTEGUMENTARY/SKIN			
Boils/Lesions			
Persistent Itch			
Skin Rash			
MUSCULOSKELETAL			
Back Pain			
History of Falls			
History of Fractures			
Joint Pain			
Neck Pain			
NEUROLOGICAL			
Dizzy Spells			
Memory Loss			
Numbness/Tingling			
Seizures			
Stroke			
Tremors			
PSYCHIATRIC			
Anxiety			
Depression			
Difficulty Sleeping			
RESPIRATORY			
Difficulty Breathing			
Frequent Cough			
History/Exposure TB			
Shortness of Breath			
Wheezing			

HABITS/SOCIAL HISTORY

Do you:	No	Yes	If Yes, how much?
Smoke Tobacco			Packs/Day
Chew Tobacco			Tins or Bags/Day
Did you Smoke?			Year Quit
How many years did you smoke?			Packs/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			

MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription (over-the-counter, supplements, herbals, etc.)

What pharmacy do you use?

Medication	Dosage	How many times a day?

IMMUNIZATIONS

	No	Yes	Date
Flu Shot			
Hepatitis B			
MMR			
Pertussis (Whooping Cough)			
Pneumonia			
Tetanus			
Zoster (Shingles)			

ALLERGIES

	No	Yes	Reaction
Aspirin			
Banana			
Bee Sting			
Codeine			
Latex			
Peanuts			
Penicillin			
Shellfish			
Sulfa			
Other			

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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
	Year		Year
	Year		Year
	Year		Year

PAST SURGERIES		**PAST ACCIDENTS**	
	Year		Year
	Year		Year
	Year		Year
	Year		Year

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:											
Spouse											

OTHER INFORMATION			**No**	**Yes**
Last Colonoscopy?		Abnormal?		
Last Sigmoidoscopy		Abnormal?		
Last Hema-Chek?		Abnormal?		
Wake in the night to go to the bathroom?				
Are you currently sexually active?				
Sexual Problems or concerns?				
Do you feel safe in your home?				
Do you have a Living Will?				
If Yes, where is it?				
If No, would you like information on Living Wills?				
Have you ever been treated for alcohol abuse?				
Have you ever been treated for drug abuse?				
Do you currently abuse any substances?				
Are you under a lot of pressure/stress at work?				
Are you under a lot of pressure/stress at home?				
Have you ever had anesthesia?				
If Yes, did you have any problems?				
Are you on a special diet?				
Are you on any food restrictions?				
If Yes, specify				
Have you had a blood transfusion in the past 6 months?				

WOMEN ONLY			**No**	**Yes**
Last Pap Smear?		Abnormal?		
Last Mammogram?		Abnormal?		
Age Periods Started?		Problems?		
Ovarian Cysts?				
Vaginal itching, burning or discharge?				
Breast lumps, disease or nipple discharge?				
Pregnant Now?				
Planning a Pregnancy?				
Nursing a Child?				
Pregnancies	#	Births	#	
Miscarriages	#	Abortions	#	
Birth Control Method				

MEN ONLY			**No**	**Yes**
Last PSA?		Abnormal?		
Last Prostate Exam?		Abnormal?		
Pain or lump(s) in testicles?				
Penile (penis) itching, burning or discharge?				
Prostate Disease or problems?				
Problems starting or stopping your urine stream?				

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

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE

REVIEWED BY PROVIDER DATE