

HEALTHCARE ASSOCIATES PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____/____/____ DATE OF LAST PHYSICAL EXAM ____/____/____
LAST NAME _____ FIRST NAME: _____
SOCIAL SECURITY NO. _____ DATE OF BIRTH: ____/____/____ AGE ____
HOME TELEPHONE NO. _____ EMERGENCY CONTACT TELEPHONE NO. _____
OCCUPATION. _____ MARITAL STATUS Married Single Divorced Widowed
INSURANCE TYPE: (CIRCLE ONE) HMO POS EPO PPO INDENIMITY WORK COMP MEDICARE

Past Medical, Family & Social History

List any PERSONAL PAST ILLNESS and/or SURGERIES and when they occurred.

Illness or Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all serious illnesses in your immediate FAMILY. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

Illness	Relationship	L/D
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Colon Cancer Screen? Yes No Type? BE Flex.Sig. FOB Date _____
Last PSA or Prostate Exam _____ Last Eye Exam _____

Are you on a special diet? Yes No (If Yes, please explain)

FEMALE: Age of FMP _____, LMP _____
Menses Regular? Yes No
G ___ P ___ AB ___ Contraception? _____
Postmenopausal Yes No
HRT/ERT? Yes No
Last Mammogram _____
Last PAP _____

Do you have ALLERGIES to Med./Foods/Pollen? Yes No (If Yes, please explain)

Substance Abuse? Yes No
Do you smoke? Ever? Yes No
If yes, how much? How long? _____
Advised to quit by DR./PAC Yes

Advanced Directive Yes No
Tattoo's Yes No
Do you drink? Ever? Yes No
If yes, how much? _____
Do you exercise regularly? Yes No
If yes, how much? _____

IMMUNIZATIONS: Flu ____/____/____ Pneu ____/____/____ Tetanus ____/____/____ Other ____/____/____

CURRENT MEDICATION/OTC/VIT. /HERBS: NO YES LIST NAME/MG DOSE/FREG.

Patient Signature: _____ Date: ____/____/____
Medical Assistance Signature: _____ Date: ____/____/____
Doctor/PAC Signature: _____ Date: ____/____/____

Review of Systems

Patient Name: _____

Date: ____/____/____

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Abnormal Weight Loss	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain on exertion	Y	N
SOB on exertion	Y	N
Calf pain on exertion	Y	N

Male

Penile discharge?	Y	N
Testicular pain?	Y	N
Penile lesions?	Y	N

Other _____
Physician use only: (Comments/Notes)

Integumentary

Skin rash	Y	N
Easy Bruising	Y	N
Nail Problems	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Joint swelling	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear pain	Y	N
Nasal obstruction	Y	N
Sore throat	Y	N
Other _____		

Genitourinary

Urine incontinence	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Sputum	Y	N
Other _____		

Hematologic/Lymphatic

Swollen nodes	Y	N
Excessive bleeding	Y	N
Other _____		

Psychologic

Do you feel sad?	Y	N
Lost interest in once enjoyed activities?	Y	N
Loss of energy	Y	N

Female

Vaginal discharge?	Y	N
Heavy flow?	Y	N
Other _____		

Patient Signature: _____ Date: ____/____/____

Medical Assistance Signature: _____ Date: ____/____/____

Physician/Provider Signature: _____ Date: ____/____/____