

INITIAL HISTORY FORM

NAME _____ DATE _____ AGE _____

Chief Complaint / What are we seeing you for today?

Past Medical History / Please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Neurologic disorders (seizures/stroke) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Abdominal Disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Other: _____ | |

Past Surgical History/ Please state date and type:

Family History /Has anyone in your family ever had:

- | | |
|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Neurologic disorders (seizures/stroke) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anesthesia problems: _____ | |

Social History/ Please check all that apply:

- | | |
|----------------------------------|--------------------|
| <input type="checkbox"/> Smoke | Packs/day : _____ |
| <input type="checkbox"/> Alcohol | Drinks/week: _____ |

Medications/ Please state dose and how often per day:

Allergies to medication/ Please state medication and type of reaction:

Review of Systems / Have you had any of the following recently?:

- | | | |
|--|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Constipation | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Vision Loss | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> History of blood clots |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> HIV exposure |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Genital lesions | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Back pain | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Seizures | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of bowel/bladder control | <input type="checkbox"/> None of the above |

For Medical Staff – Do Not Write Below This Line.

- I have reviewed the health history form with the patient in detail.
 I have advised patient to follow up with appropriate physician

Signature: _____