Patient Health History

Frederick Health Medical Group

PATIENT NAME (First, Middle, Last) DATE OF BIRTH

OCCUPATION

PRIMARY CARE PROVIDER (First and Last Name) PHARMACY PREFERENCE (Include location)

REASON FOR VISIT DATE OF ONSET OF ILLNESS/INJURY

Have you fallen in the past year? ☐ Yes ☐ No How many times? ______ Did the fall(s) result in an injury? ☐ Yes ☐ No

Do you use a walking aid or has one been recommended? ☐ Yes ☐ No ☐ N/A Details: ______

Past Medical History

Check **all** conditions you have now or have had in the past.

CANCER
- ☐ TYPE: ______ YEAR: ______

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CANCER
- ☐ TYPE: ______ YEAR: ______

CARDIOVASCULAR ***(Heart & Blood Vessels)***
- ☐ Angina (chest pain)
- ☐ Arrhythmia/irregular heartbeat
- ☐ Blood clot/DVT (deep vein thrombosis) DATE: ______
- ☐ Heart attack/MI DATE: ______
- ☐ Heart disease/Coronary artery disease
- ☐ High cholesterol/Hyperlipidemia
- ☐ MVP (mitral valve prolapse)
- ☐ Varicose veins/Peripheral vascular disease
- ☐ Hypertension/High blood pressure
- ☐ Pacemaker YEAR: ______
- ☐ Stent DATE: ______
- ☐ AICD (Automatic Implantable Cardioverter Defibrillator)

BONES, JOINTS & MUSCLES
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoporosis

MENTAL HEALTH
- ☐ Anxiety DATE: ______
- ☐ Bipolar Disorder DATE: ______
- ☐ Depression DATE: ______
- ☐ Drug/Alcohol abuse DATE: ______
- ☐ OTHER: ______ DATE: ______

HEENT ***(Head, Eyes, Ears, Nose & Throat)***
- ☐ Blind DATE: ______
- ☐ Deaf DATE: ______
- ☐ Hearing loss DATE: ______
- ☐ Glaucoma DATE: ______

PULMONARY/RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ PE (pulmonary embolism/blood clot in lung) DATE: ______
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ Currently uses a C-PAP machine
- ☐ TB (tuberculosis) DATE: ______

GENITOURINARY ***(Kidneys & Urinary Tract)***
- ☐ Renal failure
- ☐ Renal insufficiency
- ☐ UTI (urinary tract infection)

NEUROLOGIC DISORDER ***(Brain & Nervous System)***
- ☐ Alzheimer's disease
- ☐ Dementia
- ☐ MS (Multiple Sclerosis)
- ☐ Parkinson's disease
- ☐ Seizure disorder
- ☐ Stroke/CVA/TIA DATE: ______
- ☐ Myasthenia gravis
- ☐ Muscular dystrophy
- ☐ Migraines
- ☐ Scoliosis
- ☐ Rheumatoid Arthritis

HEMATOLOGIC ***(Blood & Lymph Node)***
- ☐ Anemia
- ☐ Hemophilia
- ☐ Sickle cell disease
- ☐ Clotting disorders
- ☐ Lupus

GASTROINTESTINAL ***(Stomach & Digestive)***
- ☐ Colon polyps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hepatitis – Type unknown
- ☐ Hernia
- ☐ Irritable bowel
- ☐ Stomach ulcer
- ☐ Liver disease/Cirrhosis
- ☐ Acid Reflux
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis

ENDOCRINE ***(Hormones & Metabolic)***
- ☐ Diabetes – Type I
- ☐ Diabetes – Type II
- ☐ Diabetes – Type unknown
- ☐ Thyroid dysfunction
- ☐ Hypothyroidism (low)
- ☐ Hyperthyroidism (high)
- ☐ Hemoglobin A1C
- ☐ Thyroid Cancer

IMMUNE/AUTOIMMUNE & INFECTIOUS PROBLEMS
- ☐ AIDS DATE: ______
- ☐ HIV positive DATE: ______
- ☐ MRSA (Methicillin Resistant Staph Aureus) DATE: ______
- ☐ Lyme's Disease DATE: ______

Other medical conditions not listed above: ______

Past Surgical History

Check **all** that apply and indicate which side R/L as appropriate.

- ☐ Joint surgery YEAR: ________ R/L
- ☐ Aneurysm YEAR: ________
- ☐ Angioplasty YEAR: ________
- ☐ Angio w/stent YEAR: ________
- ☐ Appendectomy YEAR: ________
- ☐ Arthroscopy YEAR: ________ LOCATION: ________ R/L
- ☐ Back surgery YEAR: ________
- ☐ Cardiac/Heart surgery YEAR: ________
- ☐ Cataract extraction YEAR: ________ R/L
- ☐ Colectomy YEAR: ________
- ☐ Colonoscopy YEAR: ________
- ☐ C- Section YEAR: ________
- ☐ Ear Tubes YEAR: ________
- ☐ Gallbladder YEAR: ________
- ☐ Gastric bypass YEAR: ________
- ☐ Hernia repair YEAR: ________
- ☐ Hip replacement YEAR: ________ R/L
- ☐ Hysterectomy YEAR: ________ Ovaries: R/L
- ☐ Knee replacement YEAR: ________ R/L
- ☐ Breast Surgery YEAR: ________ R/L
- ☐ Prostate YEAR: ________
- ☐ Thyroidectomy YEAR: ________
- ☐ Tonsillectomy YEAR: ________
- ☐ Tubal Ligation YEAR: ________
- ☐ Vasectomy YEAR: ________

OTHER SURGERIES NOT LISTED:

- ☐ OTHER ________ YEAR: ________
- ☐ OTHER ________ YEAR: ________
- ☐ OTHER ________ YEAR: ________
- ☐ OTHER ________ YEAR: ________
- ☐ OTHER ________ YEAR: ________

☐ Problems with Past Anesthesia (if yes, please list below):

____

CURRENTLY BEING TREATED WITH:

- ☐ Dialysis
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Oxygen (Day/Night) ________ liters

Family History

Has any member of your family (blood relatives) had one or more of the following diseases? If so, please mark the checkbox next to the condition and indicate which family member beside the condition name.

- ☐ Cancer/Type ________
- ☐ Cancer/Type ________
- ☐ Cancer/Type ________
- ☐ Cancer/Type ________
- ☐ Heart disease ________
- ☐ Stroke ________
- ☐ Diabetes ________
- ☐ Alcoholism ________
- ☐ High blood pressure ________
- ☐ Depression ________
- ☐ Sickle Cell ________
- ☐ Tuberculosis ________
- ☐ Glaucoma ________
- ☐ Asthma ________
- ☐ High Cholesterol ________
- ☐ Kidney disorder ________
- ☐ Dementia ________
- ☐ Gout ________
- ☐ Suicide ________
- ☐ Epilepsy ________
- ☐ Thyroid disorder ________
- ☐ Bleeding disorder ________

Social History

ALCOHOL USE

Do you drink alcohol? ☐ None ☐ Rarely (social) ☐ Often # of Drinks per week: ________ ☐ Quit If so, when? ________

What type of alcohol do you drink? ☐ Beer ☐ Wine ☐ Hard liquor

CAFFEINE USE

☐ Daily AMOUNT & TYPE ________ ☐ Sometimes AMOUNT & TYPE ________ ☐ Never

TOBACCO USE: PRESENT

Do you currently smoke cigarettes regularly (at least one a day)? ☐ No ☐ Yes

Currently on average, how many cigarettes do you smoke per day? (one pack = 20) # OF CIGARETTES: ________

TOBACCO USE: PAST

In the past, have you ever smoked cigarettes regularly (at least 100 cigarettes)? ☐ No ☐ Yes

How many years have you smoked cigarettes regularly (at least once a day)? ________ YEARS

In the past on average, how many cigarettes did you smoke per day? (one pack = 20) # OF CIGARETTES: ________

If you have quit smoking, what year did you quit? ________

Do you currently smoke cigars/pipe/smokeless tobacco? ☐ No ☐ Yes

VAPING

Do you vape? ☐ Not currently ☐ Currently If you currently vape, how long have you been vaping? ________

What type of device(s) do you use? ________ Current Strength: Previous Strength:

How many times per day do you vape? ________

Do you vape for social reasons or in an effort to quit smoking? ________

Social History, continued

DRUG USE

Present ☐ No ☐ Yes If you answered "Yes," what type(s)? ______

Past ☐ No ☐ Yes If you answered "Yes," what type(s)? ______

Age quit: ______ Date quit: ______

Medications

Please list any medication(s) you are currently taking, include prescribed medications, vitamins, supplements, and over-the-counter medications.

MEDICATION	DOSAGE/DIRECTIONS	PROBLEM BEING TREATED	PRESCRIBING DOCTOR

☐ **Medication List Copied**—see attached Medication List

Are you being treated by pain management? ☐ Yes ☐ No If so, where? ______

Allergies

Please indicate your known allergies using the checkboxes below:

☐ Aspirin
☐ Penicillin
☐ Codeine
☐ Sulfa
☐ Latex
☐ Betadine
☐ Tape
☐ IVP dye
☐ Iodine/shellfish
☐ Eggs, birds/feathers
☐ Contact dermatitis
☐ Other: ______
☐ **I have no known allergies**

Please describe your reaction(s) to allergens, if any: ______

Current Treating Physicians

CARDIOLOGIST ______ PULMONOLOGIST ______ NEUROLOGIST ______

ENDOCRINOLOGIST ______ HEMATOLOGIST/ONCOLOGIST ______ OTHER ______

PATIENT/GUARDIAN SIGNATURE ______ DATE OF BIRTH ______ DATE ______