Frederick Health

Date: _____
Patient Name: _____
DOB: _____

HEALTH HISTORY

PLEASE FILL OUT THE INFORMATION BELOW TO THE BEST OF YOUR ABILITY

Primary Care Physician: _____

Specialist(s): _____

Preferred Pharmacy: _____

Current Durable Medical Equipment (DME) if applicable: _____

PAST MEDICAL HISTORY

Have you ever had the following: (circle "yes" or "no" or leave blanks if uncertain)

Rheumatic Fever	No	Yes	Reflux / Heartburn	No	Yes
Heart Disease	No	Yes	Bleeding Tendency	No	Yes
Heart Murmur	No	Yes	Diabetes	No	Yes
High Blood Pressure	No	Yes	Thyroid Disorder	No	Yes
Elevated Cholesterol	No	Yes	Adrenal Disorder	No	Yes
Pneumonia	No	Yes	Neurologic Disorder	No	Yes
Tuberculosis	No	Yes	Stroke / TIA	No	Yes
Emphysema	No	Yes	Seizure Disorder	No	Yes
Chronic Bronchitis	No	Yes	Cancer	No	Yes
COPD	No	Yes	Kidney Disease	No	Yes
Asthma	No	Yes	Liver Disease	No	Yes
Sinus Infections	No	Yes	Hepatitis	No	Yes
Hay Fever	No	Yes	Depression	No	Yes
Sleep Disorder	No	Yes	Arthritis	No	Yes
Blood Clot (legs/lungs)	No	Yes	Glaucoma	No	Yes
Blood Disorder	No	Yes	Other (please list)	_____	
Anemia	No	Yes		_____	
Ulcers	No	Yes		_____	

CURRENT MEDICATIONS AND DOSAGES (include inhalers and over-the-counter medications):

_____
_____
_____
_____

MEDICATION ALLERGIES (include reaction):

_____

Frederick Health

Date: _____
Patient Name: _____
DOB: _____

_____
_____

PREVIOUS SURGERIES:

_____
_____
_____

FAMILY HISTORY:

Lung Disease	No	Yes
Sleep Disorder	No	Yes
Snoring	No	Yes

HEALTH MAINTENANCE:

Last Mammogram _____

Last Eye Exam _____

Last Flu Shot _____

Last Pneumonia shot (Pneumovax) _____

REVIEW OF SYSTEMS:

Do you have now or have you had within the past year: (circle "yes" or "no" or leave blank if uncertain)

Numbness	No	Yes	Chest palpitations	No	Yes
Weakness or paralysis	No	Yes	Leg cramps with walking	No	Yes
Tire easily of weakness	No	Yes	Restless legs	No	Yes
Recent weight changes	No	Yes	Difficulty swallowing	No	Yes
Change in appetite	No	Yes	Heartburn	No	Yes
Sensitivity to heat or cold	No	Yes	Nausea or vomiting	No	Yes
Persistent fever	No	Yes	Abdominal pain	No	Yes
Night sweats	No	Yes	Diarrhea	No	Yes
Skin trouble or changes	No	Yes	Constipation	No	Yes
Change in hair or nails	No	Yes	Rectal bleeding	No	Yes
Headaches	No	Yes	Black tarry stools	No	Yes
Easy bleeding or bruising	No	Yes	Frequent urination	No	Yes
Difficulty with vision	No	Yes	Painful urination	No	Yes
Eye pain	No	Yes	Urinary incontinence	No	Yes
Ringing in the ears	No	Yes	Blood in urine	No	Yes
Ear pain	No	Yes	Bed wetting	No	Yes

Frederick Health

Date: _____
Patient Name: _____
DOB: _____

Frequent nose bleeds	No	Yes	Hemorrhoids	No	Yes
Frequent colds	No	Yes	Grinding teeth	No	Yes
Nasal congestion	No	Yes	Sleep walking/talking	No	Yes
Loss of smell	No	Yes	Insomnia	No	Yes
Persistent hoarseness	No	Yes	Snoring	No	Yes
Sore throat	No	Yes	Excessive drowsiness	No	Yes
Sore tongue or gums	No	Yes	Memory loss	No	Yes
Chronic cough	No	Yes	Depression	No	Yes
Frequent cough	No	Yes	Dizziness	No	Yes
Sputum production	No	Yes	Sexual dysfunction	No	Yes
Shortness of breath	No	Yes	Menopause	No	Yes
Bloody sputum	No	Yes	Breast lumps or discharge	No	Yes
Wheezing	No	Yes	Fainting	No	Yes
Chest pain or discomfort	No	Yes	Car crash	No	Yes
Ankle swelling	No	Yes	Joint pain or stiffness	No	Yes

Do you currently smoke? No Yes

If yes, how much? _____

If no, did you ever? _____

How much of the following do you drink?

Coffee _____

Tea / Iced Tea _____

Cola / Caffeinated soda _____

Chocolate _____

Alcohol _____

Do you take any over the counter caffeine tablets or other stimulants? No Yes

Do you take any herbal remedies? No Yes

Do you use any recreational drugs? No Yes

Frederick Health

Date: _____
Patient Name: _____
DOB: _____

SOCIAL HISTORY:

Occupation: _____

Hours of work: _____ (particularly do you do any shift work, or work through the night?)

Marital Status (circle one or more)

Single

Married

Separated

Divorced

Widowed

Patient Signature _____ Physician Signature _____