Patient Health History

Sound Health Care CENTER

PATIENT INFORMATION

Full Name _____ Date of Birth (mm/dd/yyyy) _____ Today's Date _____

HEALTH CONCERNS FOR TODAY

REVIEW OF SYMPTOMS (Check box if present.)

General:	☐ Fatigue ☐ Fever ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss
Eyes:	☐ Blurred Vision ☐ Eye Drainage ☐ Eye Pain ☐ Use of Contacts ☐ Use of Glasses
E.N.T (ears, nose, throat):	☐ Ear Pain ☐ Diminished Hearing ☐ Ringing Ears ☐ Runny Nose ☐ Hoarseness ☐ Sore Throat
Cardiovascular (heart):	☐ Chest Pain, Pressure or Heaviness ☐ Palpitations ☐ Rapid Heart Beat
Respiratory (lungs):	☐ Cough ☐ Shortness of Breath ☐ Wheezing
Gastrointestinal (abdomen):	☐ Abdominal Pain ☐ Heartburn ☐ Constipation ☐ Diarrhea ☐ Blood in the Stool ☐ Dark or Tarry Stools ☐ Nausea ☐ Vomiting
Urinary / Genital:	☐ Pain with Urination ☐ Blood in the Urine ☐ Frequent urination ☐ Sexual Concerns
Musculoskeletal (bones):	☐ Back Pain ☐ Neck Pain ☐ Arthritis ☐ Joint Stiffness ☐ Muscle Aches
Dermatology (skin)/Breast:	☐ Abnormal or Changing Moles ☐ Dry Skin ☐ Rashes ☐ Breast Changes
Neurological (brain):	☐ Dizziness ☐ Fainting ☐ Headaches ☐ Weakness ☐ Numbness
Hematological (blood) / Lymphatic:	☐ Easy bruising ☐ Excessive Bleeding ☐ Swollen Glands
Endocrine (glands):	☐ Intolerance to Heat/Cold ☐ Excessive Thirst ☐ Excessive Sweating
Allergic / Immunologic:	☐ Seasonal Allergies ☐ Year around Allergies ☐ History of Allergy Injections
Psychiatric (mental health):	☐ Anxiety ☐ Depression ☐ Excessive Stress ☐ Sleep Disturbance

DETAILS / SYMPTOMS:

PHYSICIANS CURRENTLY INVOLVED IN YOUR CARE – NAME / SPECIALTY:

ALLERGIES / REACTIONS TO MEDICATION AND TYPE OF REACTION:

CURRENT MEDICATIONS, DOSAGE AND FREQUENCY:

MEDICAL CONDITIONS AND DATE DIAGNOSED:

OVERNIGHT HOSPITALIZATIONS (other than surgeries/deliveries):

SURGERIES & DATES:

PROCEDURES/SCREENING TESTS

Date of Last Physical Exam _____

Date of Immunizations	Tetanus:		Hepatitis A		Hepatitis B	
	Influenza		Pneumovax		Shingles	
Lipid Panel (cholesterol):	Date		☐ Normal	☐ Abnormal / Details		
Colonoscopy	Date		☐ Normal	☐ Abnormal / Details		
MEN: Last PSA	Date		☐ Normal	☐ Abnormal / Level		
WOMEN Last Mammogram	Date		☐ Normal	☐ Abnormal		
Last PAP Smear	Date		☐ Normal	☐ Abnormal		
Last Bone Density	Date		☐ Normal	☐ Abnormal		
Last Eye Exam	Date					
Last Dental Exam	Date					

FAMILY HISTORY

Relation	Age	Age At Death	Significant Health Issues
Father:			
Mother:			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			

SOCIAL HISTORY

Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Significant Other/Live-in Partner ☐ Gay/Lesbian

Number of Children: _____ Ages(if not adults): _____

Occupation and place of employment: _____

Hobbies: _____

HABITS

Cigarettes	☐ Never	☐ Current Smoker	Packs/day	Years Smoked:	Quit Date (If former smoker):	
Other Tobacco/Amount	☐ Pipe	☐ Cigar	☐ Snuff	☐ Chew	Amount:	
Interested in Quitting	☐ Yes	☐ No	Methods Tried In Past:			
Alcohol	☐ Non-Drinker	☐ Current Use:	Frequency:	Amount:		
History of Alcohol Abuse	☐ Yes	☐ No	Quit Date:			
Caffeine?	☐ None	☐ Coffee / Daily Amount:		☐ Tea / Daily Amount:	☐ Soda/Energy/Daily Amount:	
Recreational Drug Use:	☐ None	☐ Yes / Type		History of Abuse?	☐ Yes ☐ No	

BEHAVIORS (OPTIONAL)

Eating behaviors?	☐ Good	☐ Need to improve a little	☐ Need to improve a lot
Sleeping Pattern	☐ Healthy (7-8 Hours)	☐ Unhealthy / Average Daily Amount:	

On how many of the past seven days did you participate in:

Moderate physical activity (for example, walking or riding a bike) for at least 30 minutes?	☐ 0-1	☐ 2-3	☐ 4-5	☐ 6-7
Vigorous physical activity (for example, basketball or swimming) for at least 20 minutes?	☐ 0-1	☐ 2-3	☐ 4-5	☐ 6-7