Yearly Health History Form (PLEASE FILL OUT BOTH SIDES)

Todays Date: _____/_____/_____

NAME:_____ DOB: _____AGE:_____

Race (circle): Caucasian African American Latino Other _____ Gender (circle): Male Female

Over the past Year:

Have you developed any new medical conditions? _____

_____

Have you had any major changes to job, relationships, or home? _____

Have any previously undiagnosed medical problems developed in any blood related family member?_____

_____

Have you developed any allergies or bad reactions to medications? _____

Current Medications: Please List doses. Include birth control pills, over the counter or non-prescription supplements, vitamins, herbal preparations, or pain relievers.

_____

_____

_____

_____

Habits:

Do you use tobacco? Yes ___ No___ if so, How much per day? _____Would you like to quit? YES____ NO ____ Maybe? ____

Alcohol: Number of drinks per week including beer and wine _____

Is there anyone in your household who abuses alcohol or drugs? Yes___ No ___

Do you use marijuana? Yes___ No ___

Do you use any illegal drugs? (Cocaine, meth, etc.) Yes___ No ___ If yes, what type?_____

Do you exercise regularly? Yes___ No ___

Type of exercise and times per week _____

Review of Symptoms

Are you having problems with

Fatigue	Yes____ No____	
Fevers or Chills	Yes____ No____	
Headaches	Yes____ No____	
Sinuses/post nasal drip	Yes____ No____	
Ears or Nose	Yes____ No____	
Hearing	Yes____ No____	If yes, would you like to see an Audiologist? Yes____ No____
Eyes or Vision	Yes____ No____	
Chest Pain	Yes____ No____	
Shortness of Breath	Yes____ No____	
Snoring	Yes____ No____	
Cough	Yes____ No____	
Pain in Calves with walking	Yes____ No____	
Bowels/Diarrhea/Constipation	Yes____ No____	
Bladder/Urination	Yes____ No____	
Sexual or Erection Problems	Yes____ No____	
How many times do you urinate at night? _____		
Skin Concerns	Yes____ No____	Do you get regular skin checks with a dermatologist? Yes___No___
Anxiety/Depression	Yes____ No____	
Insomnia	Yes____ No____	
Swelling in Ankles	Yes____ No____	
Joint pains and problems	Yes____ No____	
Memory problems	Yes____ No____	
Weight Issues/Changes	Yes____ No____	
Numbness or tingling in hands/toes	Yes____ No____	

Please list any symptoms or concerns you would like to discuss with the physician today

[Please be aware that if you have multiple concerns the physician may ask you to return to discuss them at another time other that your routine exam- or you/or your insurance may be charged an additional visit charge]

Symptoms/Concerns:_____

_____

_____

_____

_____

_____

TURN OVER PAGE

Preventative Health Care

Have you been fasting for blood work today? Yes____ No____ Fasting requires no food for 12 hours prior to blood draw. You may have water, black coffee and any morning medications)

Labs already done? Yes____ No____

Would you like HIV test? Yes____ No____

(If you would like to have labs done prior to exam in the future, alert your doctor's phoning MA two weeks prior to your appointment. Make sure to advise type of insurance so you are sent to appropriate lab.)

When was your last:

Colonoscopy _____

Tetanus Shot _____

Pneumonia shot (if over 65) _____

Shingles shot (Zostavax) if over 60 _____

Flu Shot _____

Eye Exam _____

Dental Exam _____

If Female:

Last Mammogram? _____

Pap Smear? _____

Bone Density Test? _____

Do you do Self Breast Exams or Self Testicular Exams? Yes____ No____

Do you keep a record of medical problems, tests, immunizations, medications and allergies? Yes____ No____

Please list any other physicians involved in your health care: (include cardiologist, surgeons, podiatrist, ophthalmologist, neurologist, dentist, obstetrician or gynecologist, therapist or psychiatrist)

_____

_____

_____

Safety

Do you wear seat belts at all times when riding in the car? Yes____ No____

Are there functioning smoke detectors in your house? Yes____ No____

Do you wear sunscreen/protective clothing outside? Yes____ No____

FOR MEDICARE PATIENTS ONLY

Do you live alone? Yes____ No____

With whom do you live?

_____

Do you have any problems performing dressing, feeding, toileting, or grooming? Yes____ No____

Do you need help with shopping, food preparation, housekeeping, taking medicine or managing finances? Yes____ No____

Nutrition:

How many servings of fruit/vegetables do you consume per day? _____ Whole Grains?_____ Fats?_____ Protein?_____

Do you have an Advanced Directive? Yes____ No____

Do you have grab bars in your bathrooms? Yes____ No____

Do you have Throw Rugs? Yes____ No____