**MEDICAL HEALTH HISTORY FORM**

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| --- | --- | --- | --- |
| **Name** *(Last, First, M.I.):* | | * M  F | **DOB:** |
| **Marital status:** | * Single  Partnered  Married  Separated  Divorced  Widowed | | |
| **Contact Phone** | | | |
| **A ddress** | | | |
| **Email** | | | |
| **Previous or referring doctor:** | | **Date of last physical exam:** | |

Patient Signature Date

**PERSONAL HEALTH HISTORY**

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| --- | --- | --- | --- | --- | --- |
| **Childhood illness:** | | * Measles  Mumps  Rubella  Chickenpox  Rheumatic Fev er  Polio | | | |
| **Immunizations and dates:** | | | * Tetanus | * Pneumonia | |
| * Hepatitis | * Chickenpox | |
| * Influenza | * MMR *Measles, Mumps, Rubella* | |
| **List any medical problems that other doctors have diagnosed** | | | | | |
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| **Surgeries** | | | | | |
| Year | Reason | | | | Hospital |
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| **Other hospitalizations** | | | | | |
| Year | Reason | | | | Hospital |
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| **Have you ever had a blood transfusion?** |  | Yes |  | No |

**EMERGENCY CONTACT INFORMATION**

**IN CASE OF EMERGENCY, WHO MAY WE CONTACT FOR YOU?**

|  |
| --- |
| **Name** |
| **Cell Phone** |
| **Work Phone** |
| **Address** |
| **This person’s relation to you** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** | | | | | | | | | | | |
| Name the Drug | | | Strength | | | Frequency Tak en | | | | | |
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| **A llergies to medications** | | | | | | | | | | | |
| Name the Drug | | | Reaction You Had | | | | | | | | |
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| **HEALTH HABITS AND PERSONAL SAFETY** | | | | | | | | | | | |
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| ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. | | | | | | | | | | | |
| **Exercise** | * Sedentary (No exercise) | | | | | | | | | | |
| * Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | | | | | | | |
| * Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | | | | | | |
| * Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | | | | | | | |
| **Diet** | Are you dieting? | | | | | | |  | Yes |  | No |
| If yes, are you on a physician prescribed medical diet? | | | | | | |  | Yes |  | No |
| # of meals you eat in an av erage day ? | | | | | | | | | | |
| Rank salt intak e | * Hi | | * Med | * Low | | | | | | |
| Rank fat intak e | * Hi | | * Med | * Low | | | | | | |
| **Caffeine** | * None | * Coffee | | * Tea | * Cola | | | | | | |
| # of cups/cans per day ? | | | | | | | | | | |
| **Alcohol** | Do you drink alcohol? | | | | | | |  | Yes |  | No |
| If yes, what kind? | | | | | | | | | | |
| How many drinks per week ? | | | | | | | | | | |
| Are you concerned about the amount you drink? | | | | | | |  | Yes |  | No |
| Have you considered stopping? | | | | | | |  | Yes |  | No |
| Have you ev er experienced blackouts? | | | | | | |  | Yes |  | No |
| Are you prone to “binge” drinking? | | | | | | |  | Yes |  | No |
| Do you drive after drinking? | | | | | | |  | Yes |  | No |
| **Tobacco** | Do you use tobacco? | | | | | | |  | Yes |  | No |
| * Cigarettes – pk s./day | | | * Chew - #/day | * Pipe - #/day | | * Cigars - #/day | | | | |
| * # of y ears | * Or y ear quit | | | | | | | | | |
| **Drugs** | Do you currently use recreational or street drugs? | | | | | | |  | Yes |  | No |
| Have you ev er giv en yourself street drugs with a needle? | | | | | | |  | Yes |  | No |

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| **Sex** | Are you sexually active? |  | Yes |  | No |
| If yes, are you trying for a pregnancy? |  | Yes |  | No |
| If not trying for a pregnancy list contraceptiv e or barrier method used: | | | | |
| Any discomfort with intercourse? |  | Yes |  | No |
| Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? |  | Yes |  | No |
| **Personal Safety** | Do you live alone? |  | Yes |  | No |
| Do you have frequent falls? |  | Yes |  | No |
| Do you have vision or hearing loss? |  | Yes |  | No |
| Do you have an Advance Directive or Living Will? |  | Yes |  | No |
| Would you like information on the preparation of these? |  | Yes |  | No |
| Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? |  | Yes |  | No |

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| **FAMILY HEALTH HISTORY** | | | | | |
|  | | | | | |
|  | AGE | SIGNIFICANT HEALTH PRO BLEMS |  | AGE | SIGNIFICANT HEALTH PRO BLEMS |
| **Father** |  |  | **Children** | * M * F |  |
| **Mother** |  |  | * M * F |  |
| **Sibling** | * M * F |  | * M * F |  |
| * M * F |  | * M * F |  |
| * M * F |  | **Grandmother**  *Maternal* |  |  |
| * M * F |  | **Grandfather**  *Maternal* |  |  |
| * M * F |  | **Grandmother**  *Paternal* |  |  |
| * M * F |  | **Grandfather**  *Paternal* |  |  |

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| **MENTAL HEALTH** | | | | |
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| Is stress a major problem for you? |  | Yes |  | No |
| Do you feel depressed? |  | Yes |  | No |
| Do you panic when stressed? |  | Yes |  | No |
| Do you have problems with eating or your appetite? |  | Yes |  | No |
| Do you cry frequently? |  | Yes |  | No |
| Have you ev er attempted suicide? |  | Yes |  | No |
| Have you ev er seriously thought about hurting yourself? |  | Yes |  | No |
| Do you have trouble sleeping? |  | Yes |  | No |
| Hav e you ev er been to a counselor? |  | Yes |  | No |

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| --- | --- | --- | --- | --- | --- |
|  | Skin |  | Chest/Heart |  | Recent changes in: |
|  | Head/Neck |  | Back |  | Weight |
|  | Ears |  | Intestinal |  | Energy lev el |
|  | Nose |  | Bladder |  | Ability to sleep |
|  | Throat |  | Bowel |  | O ther pain/discomfort: |
|  | Lungs |  | Circulation |  | |

**Patient Privacy Form**

**Patient’s Name:**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, and if so you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**The patient understands that:**

* Protected health information may be disclosed or used for treatment, payment or health care operations. 
* All other disclosures by the practice will require specific authorization by you unless required by law. 
* The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice and receive a copy. 
* The Practice reserves the right to change the Notice of Privacy Policies. The new policy will be posted in the lobby and on the web site. 
* The patient has the right to restrict the uses of their information used for treatment, payment or operations, but the Practice does not have to agree to those restrictions.



**Patient/Guardian: Date:** 

**Practice Representative: Date:** 