# FCHC Medical Care - PATIENT HEALTH HISTORY FORM

**PLEASE COMPLETE IN BLACK INK**

TODAY'S DATE



| LAST NAME | LEGAL FIRST NAME | MI | DATE OF BIRTH |
|---|---|---|---|
| | | | |

## YOUR HEALTH HISTORY

| Check all items either No or Yes | No | Yes, Now | Yes, Past |
|---|---|---|---|
| **ALLERGY** | | | |
| Drug Allergies | | | |
| Hay Fever | | | |
| Latex Allergy | | | |
| **CARDIOVASCULAR** | | | |
| Chest Pain | | | |
| Heart Defects | | | |
| Heart Murmur | | | |
| High Blood Pressure | | | |
| Low Blood Pressure | | | |
| Palpitations | | | |
| Varicose Veins | | | |
| **CONSTITUTIONAL** | | | |
| Chills | | | |
| Fatigue or Weakness | | | |
| Fever | | | |
| Headache (Frequent) | | | |
| Weight Gain | | | |
| Weight Loss | | | |
| **EAR/NOSE/THROAT** | | | |
| Difficulty Hearing | | | |
| Ear Infections | | | |
| Ringing Ears | | | |
| Sinus Trouble | | | |
| Sore Throat | | | |
| **ENDOCRINE** | | | |
| Cold Intolerance | | | |
| Excessive Thirst | | | |
| Heat Intolerance | | | |
| Thyroid Trouble | | | |
| Tired/Sluggish | | | |

| Check all items either No or Yes | No | Yes, Now | Yes, Past |
|---|---|---|---|
| **EYES** | | | |
| Blurred Vision | | | |
| Double Vision | | | |
| Eye Pain | | | |
| Failing Vision | | | |
| Vision Loss | | | |
| **GASTROINTESTINAL** | | | |
| Abdominal Pain | | | |
| Appetite Loss | | | |
| Blood in Stool | | | |
| Constipation | | | |
| Diarrhea | | | |
| GI Bleed | | | |
| Indigestion/Heartburn | | | |
| Nausea/Vomiting | | | |
| Ulcers/Reflux/GERD | | | |
| **GENITOURINARY** | | | |
| Bladder Leakage | | | |
| Blood in Urine | | | |
| Painful Urination | | | |
| Urinary Frequency | | | |
| Urine Retention | | | |
| **HEMATOLOGIC/LYMPHATIC** | | | |
| Abnormal Bleeding | | | |
| Bleeding Disorders | | | |
| Blood Clotting Problems | | | |
| Swollen Glands | | | |

| Check all items either No or Yes | No | Yes, Now | Yes, Past |
|---|---|---|---|
| **INTEGUMENTARY/SKIN** | | | |
| Boils/Lesions | | | |
| Persistent Itch | | | |
| Skin Rash | | | |
| **MUSCULOSKELETAL** | | | |
| Back Pain | | | |
| History of Falls | | | |
| History of Fractures | | | |
| Joint Pain | | | |
| Neck Pain | | | |
| **NEUROLOGICAL** | | | |
| Dizzy Spells | | | |
| Memory Loss | | | |
| Numbness/Tingling | | | |
| Seizures | | | |
| Stroke | | | |
| Tremors | | | |
| **PSYCHIATRIC** | | | |
| Anxiety | | | |
| Depression | | | |
| Difficulty Sleeping | | | |
| **RESPIRATORY** | | | |
| Difficulty Breathing | | | |
| Frequent Cough | | | |
| History/Exposure TB | | | |
| Shortness of Breath | | | |
| Wheezing | | | |

## HABITS/SOCIAL HISTORY

| Do you: | No | Yes | If Yes, how much? |
|---|---|---|---|
| Smoke Tobacco | | | Packs/Day |
| Chew Tobacco | | | Tins or Bags/Day |
| **Did you Smoke?** | | | Year Quit |
| How many years did you smoke? | | | Packs/Day |
| Drink Alcohol or Wine | | | Drinks/Day |
| Drink Beer | | | Cans/Day |
| Drink Caffeine | | | Cups/Day |
| Use Recreational Drugs | | | |
| Exercise | | | |
| Live Alone | | | |
| History of Falls | | | |
| History of Fractures | | | |

## MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription (over-the-counter, supplements, herbals, etc.)

**What pharmacy do you use?**

| Medication | Dosage | How many times a day? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## IMMUNIZATIONS

| | No | Yes | Date |
|---|---|---|---|
| Flu Shot | | | |
| Hepatitis B | | | |
| MMR | | | |
| Pertussis (Whooping Cough) | | | |
| Pneumonia | | | |
| Tetanus | | | |
| Zoster (Shingles) | | | |
| | | | |
| | | | |
| | | | |

## ALLERGIES

| | No | Yes | Reaction |
|---|---|---|---|
| Aspirin | | | |
| Banana | | | |
| Bee Sting | | | |
| Codeine | | | |
| Latex | | | |
| Peanuts | | | |
| Penicillin | | | |
| Shellfish | | | |
| Sulfa | | | |
| Other | | | |
| | | | |

# FCHC Medical Care - PATIENT HEALTH HISTORY FORM

**PLEASE COMPLETE IN BLACK INK**

TODAY'S DATE | PAGE 2

| LAST NAME | LEGAL FIRST NAME | MI | DATE OF BIRTH |
|---|---|---|---|
| | | | |

**Are you being treated by other Healthcare Professionals?** No Yes **If yes, please list doctors & reasons for treatment.**

Physician/Specialist
Dentist
Chiropractor

| **HOSPITALIZATIONS (NOT INCLUDING NORMAL PREGNANCIES)** | | **SERIOUS ILLNESS (NOT REQUIRING HOSPITALIZATION)** | |
|---|---|---|---|
| | Year | | Year |
| | Year | | Year |
| | Year | | Year |
| | Year | | Year |

| **PAST SURGERIES** | | **PAST ACCIDENTS** | |
|---|---|---|---|
| | Year | | Year |
| | Year | | Year |
| | Year | | Year |
| | Year | | Year |

**FAMILY HISTORY**

| | **Living** | **Deceased** | Year of Birth | Age | Hypertension | Diabetes | Heart Disease | Stroke | Mental Illness | Cancer: List Type | Other Health Issue: List |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | | | | |
| Mother | | | | | | | | | | | |
| Father's Grandfather | | | | | | | | | | | |
| Father's Grandmother | | | | | | | | | | | |
| Mother's Grandfather | | | | | | | | | | | |
| Mother's Grandmother | | | | | | | | | | | |
| Son(s) | | | | | | | | | | | |
| Daughter(s) | | | | | | | | | | | |
| Siblings: | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| Spouse | | | | | | | | | | | |

| **OTHER INFORMATION** | | | **No** | **Yes** |
|---|---|---|---|---|
| Last Colonoscopy? | | Abnormal? | | |
| Last Sigmoidoscopy | | Abnormal? | | |
| Last Hema-Chek? | | Abnormal? | | |
| Wake in the night to go to the bathroom? | | | | |
| Are you currently sexually active? | | | | |
| Sexual Problems or concerns? | | | | |
| Do you feel safe in your home? | | | | |
| Do you have a Living Will? | | | | |
| If Yes, where is it? | | | | |
| If No, would you like information on Living Wills? | | | | |
| Have you ever been treated for alcohol abuse? | | | | |
| Have you ever been treated for drug abuse? | | | | |
| Do you currently abuse any substances? | | | | |
| Are you under a lot of pressure/stress at work? | | | | |
| Are you under a lot of pressure/stress at home? | | | | |
| Have you ever had anesthesia? | | | | |
| If Yes, did you have any problems? | | | | |
| Are you on a special diet? | | | | |
| Are you on any food restrictions? | | | | |
| If Yes, specify | | | | |
| Have you had a blood transfusion in the past 6 months? | | | | |

| **WOMEN ONLY** | | | **No** | **Yes** |
|---|---|---|---|---|
| Last Pap Smear? | | Abnormal? | | |
| Last Mammogram? | | Abnormal? | | |
| Age Periods Started? | | Problems? | | |
| Ovarian Cysts? | | | | |
| Vaginal itching, burning or discharge? | | | | |
| Breast lumps, disease or nipple discharge? | | | | |
| Pregnant Now? | | | | |
| Planning a Pregnancy? | | | | |
| Nursing a Child? | | | | |
| Pregnancies | # | Births | # | |
| Miscarriages | # | Abortions | # | |
| Birth Control Method | | | | |
| | | | | |

| **MEN ONLY** | | | **No** | **Yes** |
|---|---|---|---|---|
| Last PSA? | | Abnormal? | | |
| Last Prostate Exam? | | Abnormal? | | |
| Pain or lump(s) in testicles? | | | | |
| Penile (penis) itching, burning or discharge? | | | | |
| Prostate Disease or problems? | | | | |
| Problems starting or stopping your urine stream? | | | | |

The information on this Patient Health History Form is correct to the best of my knowledge.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE

REVIEWED BY PROVIDER DATE