partnership HEALTH CENTER
PHCTR Integrity Health

Partnership Health Center

PATIENT HISTORY FORM

DATE: _____

NAME: _____ **AGE**:_____ **DATE OF BIRTH**: _____

PAST MEDICAL HISTORY

Surgeries and dates:

_____ _____
_____ _____

Hospitalizations: (other than for surgeries)

Date: _____ Where: _____ Reason? _____
_____ _____
_____ _____

Injuries/Fractures (type, date and how injured):

_____ _____
_____ _____

What medications are you currently taking? (prescription, over-the-counter, herbs and supplements):

Name Dose #Taken daily Reason

_____
_____
_____
_____
_____

Allergies: ❑ No ❑ Yes (If yes, please list)

_____
_____
_____

Immunizations: Please check if you have had any of the following.

DPT _____ Mumps _____ Measles _____ Rubella _____ Polio ____ Smallpox _____

Tetanus Booster	Date: _____	Tetanus Booster	Date: _____
Pneumovax (pneumonia vaccine)	Date: _____	Pneumovax (pneumonia vaccine)	Date: _____
Influenza (date of last shot)	Date: _____	Influenza (date of last shot)	Date: _____
Hepatitis B (series of 3 shots)	Date: _____	Hepatitis B (series of 3 shots)	Date: _____

Others: _____

LIFESTYLE HISTORY

Marital Status:

Single ❑ Married ❑ Divorced ❑ Widowed ❑
Significant Other (male) ❑ Significant other (female) ❑

Have you ever been pregnant? Yes ❑ No ❑ N/A ❑

If yes, how many pregnancies? _____ How many live births? _____

FAMILY HISTORY

Mother: Age (if living) _____ Age (at death) _____ Father: Age (if living) _____ Age (at death) _____

List any relatives with the following history:

	Relationship		Relationship
Diabetes	_____	High blood pressure	_____
Heart attack	_____	Breast cancer	_____
Stroke	_____	Colon cancer	_____
Tuberculosis	_____	High cholesterol	_____
Alzheimer's	_____	Melanoma (skin cancer)	_____
Prostate cancer	_____	Ovarian cancer	_____

Exercise:

Do you exercise regularly? _____ What activity? _____

How often?_____ How long is each session? _____

Diet -Check any foods you **avoid** in your diet:

❑ salt ❑ sugar ❑ fats (oils) ❑ red meat ❑ eggs ❑ poultry ❑ wheat ❑ caffeine

❑ other:_____

Usual number of meals per day: _____ Number of times per week you eat "fast foods" _____

Travel: Have you recently traveled outside the U.S.? _____

Where did you go? _____

Work: Current Occupation: _____

Have you had any work related illnesses or injuries? ❑ Yes ❑ No If yes, please explain.

Injury/Illness: while employed as:

_____ _____

Do you have a history of exposure to toxic chemicals or substances? ❑ Yes ❑ No

Please explain: _____

_____

REVIEW OF SYSTEMS

In the past, have you been diagnosed as having any of the following conditions? Check and date:

❑	High blood pressure		❑	Varicose veins	
❑	Hardening of the arteries		❑	Phlebitis (blood clots)	
❑	Heart attack		❑	Migraine headaches	
❑	Stroke or "TIA"		❑	Cluster headaches	
❑	Heart Murmur		❑	Tension headaches	
❑	Angina		❑	Congestive heart failure	
❑	Cataracts		❑	Glaucoma	
❑	Sinusitis		❑	Menieres Disease	
❑	Nasal polyps		❑	Allergic rhinitis	
❑	Tonsillitis		❑	Gum disease	
❑	Cervical (neck) strain		❑	Arthritis	

REVIEW OF SYSTEMS (continued)

❑ Lupus		❑ Rheumatoid arthritis	
❑ Emphysema		❑ Chronic bronchitis	
❑ Pneumonia		❑ Asthma	
❑ Fibrocystic breast disease		❑ Galactorrhea(breast discharge)	
❑ Hyperthyroidism (over-active thyroid)		❑ Hypothyroidism (low thyroid)	
❑ Pernicious anemia		❑ Lymphoma	
❑ Peptic ulcer (gastric or duodenal)		❑ Iron deficiency anemia	
❑ Gastritis/Esophagitis		❑ Giardia or other parasite	
❑ Intestinal polyps		❑ Malabsorption	
❑ Diverticulosis		❑ Diverticulitis	
❑ Irritable bowel (spastic colon)		❑ Chronic Fatigue syndrome	
❑ Reflux or GERD		❑ Enlarged prostate	
❑ Fibromyalgia		❑ Crohn's colitis	
❑ Ulcerative colitis		❑ Prostatitis (prostate infection)	
❑ Hemorrhoids		❑ Pelvic inflammatory disease	
❑ Epididymitis		❑ Uterine Fibroids	
❑ Dysmenorrhea		❑ Cystitis(bladder infection)	
❑ Vaginitis		❑ Hepatitis A, B or C	
❑ Pyelonephritis (kidney infection)		❑ Diabetes	
❑ Kidney Stone		❑ Gallstones	
❑ Hypoglycemia		❑ PMS or PMDD	
❑ Bulimia or Anorexia		❑ Depression	
❑ Any kind of Cancer		❑ Multiple sclerosis	
What kind?		❑ Neurologic disease	
❑ Abnormal x-ray findings:		❑ Panic attacks	
Describe		❑ High cholesterol or Triglycerides	
❑ Abnormal pap smear		❑ Sexual dysfunction	

Presently or in the recent past, have you had any of the following symptoms:

- ❑ Change in appetite
- ❑ Nausea
- ❑ Change in bowel habits
- ❑ Painful urination
- ❑ Breast Pain
- ❑ Easy bruising or bleeding
- ❑ Night Sweats
- ❑ Change in vision
- ❑ Frequent nosebleeds
- ❑ Constant sinus drainage
- ❑ Swollen glands
- ❑ Shortness of breath while laying down
- ❑ Feeling faint or almost passing out
- ❑ Heartburn or indigestion
- ❑ Vomiting
- ❑ Blood in or on stool
- ❑ Blood in urine
- ❑ Change in menstrual periods
- ❑ Breast lump
- ❑ Testicular pain
- ❑ Abdominal burning pain
- ❑ Diarrhea
- ❑ Rectal bleeding
- ❑ Change in urinary habits
- ❑ Weight gain

  # of pounds gained _____
- ❑ Generalized body aches
- ❑ Change in hearing
- ❑ Recurrent gum/tooth infections
- ❑ Trouble swallowing
- ❑ Shortness of breath on exertion
- ❑ Chronic cough
- ❑ Coughing up phlegm - morning
- ❑ Swollen ankles or feet
- ❑ Abdominal cramping pain
- ❑ Constipation
- ❑ Frequent /urgent urination
- ❑ Vaginal discharge or odor
- ❑ Change in sexual desire
- ❑ Nipple discharge
- ❑ Trouble sleeping
- ❑ Muscle weakness or pain
- ❑ Joint swelling
- ❑ Changes in skin or moles
- ❑ Sensation of being too hot / too cold
- ❑ Memory loss
- ❑ Mood swings
- ❑ Joint pains
- ❑ Head injury / loss of consciousness
- ❑ Depression
- ❑ Tingling in hands or feet
- ❑ Testicular swelling
- ❑ Lumps in neck, underarms or groin
- ❑ Nervousness, panic
- ❑ Numbness
- ❑ Seizures or convulsions
- ❑ Changes in hair
- ❑ Skin rash

List any other problems not mentioned above:

_____

_____

HEALTH MAINTENANCE

Date of last physical/annual exam_____ Date of last Pap smear _____

Date of Last

Cholesterol screen _____ EKG _____ Chest X-ray _____ Prostate exam _____

Complete blood tests _____ Thyroid level _____ Sigmoid/Colonoscopy _____

Bone density test _____ Mammogram _____

Do you use a seat belt in your car? _____

CHIEF COMPLAINT: Please list below the main reason for your visit today and other specific concerns or problems you want the doctor to discuss with you. **Reason for visit:** _____

_____

_____

_____

_____

_____

_____

Signature of patient or guardian: _____

Date: _____