

# CHRISTIE MEDICAL CLINIC INC

## Health History Form / New Patient

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Previous Medical Providers name and address: \_\_\_\_\_

Emergency contact name (and relation to patient) and phone #: \_\_\_\_\_

**ALLERGIES:**

**MEDICATIONS (PRESCRIPTION & OVER THE COUNTER MEDICINE) INCLUDE NAME, DOSAGE & FREQUENCY:**

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

**MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS**

PROBLEM/DATE	PROBLEM/DATE	PROBLEM/DATE

Have you had a transfusion of blood or blood products?  Yes  No      If yes did you have any reaction?  Yes  No

**PERSONAL & SOCIAL HISTORY**

**ALCOHOL/TOBACCO/DRUGS RISK SCREEN:**

- Do you use cigarettes, pipes, cigars or chew tobacco?  Yes  No
- Do you drink alcohol?  Yes  No      If, yes answer questions below.
  - Ever tried to cut back on the amount of alcohol you drink?  Yes  No
  - Ever become angry when people discuss your alcohol?  Yes  No
  - Ever felt guilty about anything you did because of your drinking?  Yes  No
  - Ever had a drink before noon (eye opener)?  Yes  No
  - Has your drinking affected your relationship with your family or friends?  Yes  No
  - Has your drinking affected your work or school?  Yes  No
  - Have you ever drunk alcohol while or before driving or driven while intoxicated?  Yes  No
- Do you drink coffee, sodas or other caffeinated beverages?  Yes  No
- Do you use any street drugs or abuse prescription pain medication?  Yes  No

**SOCIAL HISTORY**

- Do you think you are at risk for HIV, AIDS or other sexually Transmitted disease?  Yes  No
- Have you ever been tested for HIV?  Yes  No
  - If yes, when \_\_\_\_/\_\_\_\_.      What was the Result? \_\_\_\_
- Marital status:  Married       Single       Divorced       Widow(er)       Separated
- Education:  Jr. High School       High School/GED       Vocational School       College       Other: \_\_\_\_\_
- Occupation: \_\_\_\_\_      Do you have an Advance Directive?  Yes  No

**FAMILY HISTORY**

FAMILY MEMBER	AGE	ALIVE / DECEASED	HEALTH	CAUSE OF DEATH
Father		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
Mother		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
1. <input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
2. <input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		

More questions on back.

Please turn over

FAMILY HISTORY		RELATIVE			RELATIVE
1. Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	11. Iron Storage Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. Breast Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	12. High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	13. Ovarian Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	14. Prostate Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. Depression, Suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	15. Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	16. Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7. High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	17. Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8. Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	18. Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
9. Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	19. Macular degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
10. Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	20. Other:		_____

**HEALTH MAINTENANCE**

Last Stools, occult blood test: \_\_\_\_/\_\_\_\_ Colonoscopy/Sigmoidoscopy: \_\_\_\_/\_\_\_\_

Dental Exam: \_\_\_\_/\_\_\_\_ Dilated Eye Exam: \_\_\_\_/\_\_\_\_ Foot Exam: \_\_\_\_/\_\_\_\_

WOMEN: Last: PAP smear: \_\_\_\_/\_\_\_\_ Mammogram: \_\_\_\_/\_\_\_\_ Breast Exam: \_\_\_\_/\_\_\_\_ Menstrual Period: \_\_\_\_/\_\_\_\_/\_\_\_\_

MEN: Last: Rectal/Prostate exam: \_\_\_\_/\_\_\_\_ Testicular Exam: \_\_\_\_/\_\_\_\_ PSA: \_\_\_\_/\_\_\_\_

IMMUNIZATIONS: (last date/year received) Tetanus: \_\_\_\_\_ Hepatitis B vaccine: \_\_\_\_\_ MMR: \_\_\_\_\_

Pneumonia: \_\_\_\_\_ Flu: \_\_\_\_\_ Tuberculosis Skin Test (date & results): \_\_\_\_\_

**Please review the list of symptoms below.**

Check "Yes" box if you suffer from the symptoms or have any of the health issues listed in the past 6 months Check "No" box if you do not.

<p><b>CONSTITUTIONAL</b></p> <p>Unexplained weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Unexplained weight gain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fevers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chills <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nausea or Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Eyes</b></p> <p>Cataract <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Change in vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Red eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>ENMT</b></p> <p>Bleeding from gums <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems hearing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Change in your voice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Denture <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nose bleeds <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hoarse voice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinus problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ringing in ears <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mouth ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>CARDIOVASCULAR</b></p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leg pain with walking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems with exercise <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swelling in legs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems lying flat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Skipping heart beats <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Short of breath at night <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>RESPIRATORY</b></p> <p>Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Coughing up blood <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>SKIN</b></p> <p>Skin changes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Skin lesions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Skin itching <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rashes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry skin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>GASTROINTESTINAL</b></p> <p>Blood in stool <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Change in movements <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart burn <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hemorrhoids <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Black tarry stool <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nausea or vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>GENITOURINARY</b></p> <p>Problems urinating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood in urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hernias <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Incontinence <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Urination at night <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexual transmitted Dz. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Urinary urgency <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>WOMEN ONLY</b></p> <p>Problems with your period <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vaginal dryness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems with sex <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vaginal discharge <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain in breast <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lumps in breast <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Breast discharge <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>MEN ONLY</b></p> <p>Problems with erections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dribbling of urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weak urine stream <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain in testicles <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>MUSCULAR SKELETAL</b></p> <p>Neck pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gout <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Injury to limbs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint stiffness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Locking joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Back pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Red or Swollen in joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>HEMATOLOGY/ONCOLOGY</b></p> <p>Anemia or low blood <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily bruise <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen lymph nodes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>PSYCHIATRIC</b></p> <p>Depression or Sadness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Feel like hurting someone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Feel like hurting yourself <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems with memory <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems concentrating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems sleeping <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>NEUROLOGY</b></p> <p>Change in memory <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Imbalance <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Numbness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tremors <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>ENDOCRINE</b></p> <p>Problems with heat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems with cold <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swelling in neck <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent urination <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Excessive thirst <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Changes in hair <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Print Name & Sign \_\_\_\_\_

Date \_\_\_\_\_

Physician Signature reviewing Data & Date \_\_\_\_\_