



## PATIENT HEALTH INFORMATION

To best care for you, please provide the following information. All information is strictly confidential and is released only with your written consent. Please complete all pages and bring them to your initial appointment.

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **M.I.** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**By what name should we call you?** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Preferred Language:** \_\_\_\_\_

<p><b>RACE:</b></p> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Decline	<p><b>ETHNICITY:</b></p> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Decline	<p><b>BIRTH SEX:</b></p> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
<p><b>SEXUAL ORIENTATION:</b></p> <input type="checkbox"/> Lesbian, gay or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Other <input type="checkbox"/> Decline	<p><b>GENDER IDENTITY:</b></p> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Male to female transgender <input type="checkbox"/> Female to male transgender <input type="checkbox"/> Genderqueer, neither male nor female <input type="checkbox"/> Other <input type="checkbox"/> Decline	

**Primary Care Provider:** \_\_\_\_\_

**Additional Providers:** \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_ **Location:** \_\_\_\_\_

**ALLERGIES**

Allergic reaction to?  Latex       Adhesive tape       IV Contrast

If allergic to any of the above, describe reaction: \_\_\_\_\_

**Allergies to any Medications:**                      **Type of Reaction:**


Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PAST AND CURRENT MEDICAL CONDITIONS**

Have you ever received chemotherapy/immunotherapy?

No  Yes, treatment location: \_\_\_\_\_

Have you ever received radiation therapy?

No  Yes, treatment location: \_\_\_\_\_

Please indicate if you have or have ever had the following:

**Y N**

- Anemia or Blood Disorder
- Anxiety
- Arthritis
- Asthma
- Autoimmune Disorder
- Blood Clots
- Blood Transfusions (if yes, when? \_\_\_\_\_)
- Depression
- Diabetes (if yes, type? \_\_\_\_\_)
- Diverticulosis/ Colon Problems
- Emphysema
- Gallstones
- Gastroesophageal Reflux Disease
- Heart Attack/ Heart Disease
- Hepatitis/ Jaundice
- Irregular Heart Rhythm

**Y N**

- High Cholesterol
- High Blood Pressure
- History of Pneumonia (if yes, when? \_\_\_\_\_)
- Kidney Stones
- Lupus
- Obstructive Sleep Apnea
- Pacemaker
- Previous Cancers
- Rheumatic Fever
- Seizure
- Scleroderma
- Stroke/TIA
- Thyroid Problems
- Tuberculosis (TB)
- Ulcers

Additional Information: \_\_\_\_\_  
\_\_\_\_\_

Please list your previous surgeries/procedures (type of surgery/procedure with body part)

**Year:                      Surgery and Where Surgery was Completed:**




Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever used the following:

	TYPE	AMOUNT AND FREQUENCY	LENGTH OF USE	IF STOPPED, WHEN	DO YOU WANT INFORMATION ON STOPPING?
Tobacco					<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Decline
Alcohol					<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Decline
Recreation/Street Drugs					<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Decline

**FEMALE HEALTH HISTORY (If not applicable, please proceed to next section)**

At what age did you start menstruating? \_\_\_\_\_

Are you post-menopausal?  No  Yes Age of onset of menopause? \_\_\_\_\_

Have you used hormone replacement therapy?  No  Yes Years of use? \_\_\_\_\_ When was it stopped? \_\_\_\_\_

Date of last Mammogram? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Number of pregnancies? \_\_\_\_ Number of births? \_\_\_\_ Number of miscarriages? \_\_\_\_ Number of children? \_\_\_\_

**REVIEW OF SYSTEMS**

**General**

**Y N Explain if YES:**

- Poor appetite  Y  N \_\_\_\_\_
- Decreased energy/fatigue  Y  N \_\_\_\_\_
- Generalized weakness  Y  N \_\_\_\_\_
- Weight loss  Y  N \_\_\_\_\_
- Fever  Y  N \_\_\_\_\_
- Drenching night sweats  Y  N \_\_\_\_\_
- Hot flashes  Y  N \_\_\_\_\_

**Infectious Disorders**

- Frequent infection  Y  N \_\_\_\_\_
- Severe infection  Y  N \_\_\_\_\_

**Hematologic**

- Excessive bruising  Y  N \_\_\_\_\_
- Spontaneous bleeding  Y  N \_\_\_\_\_

**Lymphatic**

- Enlarged lymph nodes  Y  N \_\_\_\_\_

**Eyes**

- Blurred vision  Y  N \_\_\_\_\_
- Double vision  Y  N \_\_\_\_\_

**Ears, Nose, Mouth, Throat**

- Hearing loss  Y  N \_\_\_\_\_
- Ringing in ears  Y  N \_\_\_\_\_
- Mouth sores  Y  N \_\_\_\_\_
- Dry mouth  Y  N \_\_\_\_\_

**Heart**

- Chest pain/chest pressure  Y  N \_\_\_\_\_
- Palpitations  Y  N \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

	Y	N	
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Respiratory</b>			
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain with inspiration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Abdomen</b>			
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	_____
Black stools	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Urinary</b>			
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urination during the night	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequency	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Gynecologic</b>			
Postmenopausal vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Musculoskeletal</b>			
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Skin</b>			
Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lesions/lumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Neurologic</b>			
Headache	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Altered consciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Falls	<input type="checkbox"/>	<input type="checkbox"/>	_____

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**Psychiatric**

**Y N**

Anxiety   \_\_\_\_\_

Depression   \_\_\_\_\_

Thoughts of suicide   \_\_\_\_\_

Trouble sleeping   \_\_\_\_\_

**Breasts**

Lumps   \_\_\_\_\_

Tenderness   \_\_\_\_\_

Discharge/drainage   \_\_\_\_\_

Skin changes   \_\_\_\_\_