EAST TEXAS PRIMARY CARE

Patient Health History

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth: / /

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. We really want to know you well so we can properly care for you. If you cannot remember specific details, please provide your best guess. Thank you!

Who referred you to my practice? (check one) ☐ patient ☐ family member ☐ physician ☐ assigned Name? ___________________

Main reason for upcoming visit: ____

Other concerns: ____

How would you rate your health? (check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list healthcare providers and their specialty you see regularly: ___________________________________

____

List any medical suppliers you use (e.g. respiratory supplies, etc.): ___________________________________

MEDICATIONS

Please list **all** (or provide us your own printed record) prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc.)

☐ Check box if you do not take any prescription or over the counter medications
☐ Check box if you are providing a list of your medications (do not write in medications below)

Medication	Dose (mg/pill)	How many times per day?

Please list additional medications on a separate sheet.

ALLERGIES or intolerance to medications? ☐ NONE

If yes, to what & what reaction? ____

MEDICAL HISTORY

Do you have now, or have you had (past) any of the following conditions? ☐ **No history of significant medical illness**

Condition	**Now**	**Past**	**Comments**
Alcohol / Drug Abuse	☐	☐	
Allergy (Hay Fever)	☐	☐	
Anemia	☐	☐	
Anxiety	☐	☐	
Arthritis (Rheumatoid)	☐	☐	
Arthritis (Osteoarthritis)	☐	☐	
Asthma	☐	☐	
Bladder / Kidney Problems	☐	☐	
Blood Clot (leg)	☐	☐	
Blood Clot (lung)	☐	☐	
Blood Transfusion	☐	☐	
Breast Lump (benign)	☐	☐	
Cancer	☐	☐	Type?
Cataracts	☐	☐	
Chicken Pox	☐	☐	

Please go to next page

Medical History continued

MEDICAL HISTORY	Condition	Now	Past	Comments
	Colon Polyp	☐	☐	
	Coronary Artery Disease	☐	☐	
	Depression	☐	☐	
	Diabetes (adult onset)	☐	☐	
	Diabetes (childhood onset)	☐	☐	
	Diverticulosis	☐	☐	
	Emphysema (COPD)	☐	☐	
	Fractures (broken bones)	☐	☐	Where?
	Gallbladder Disease	☐	☐	
	Gastroesophageal Reflux (Heartburn)	☐	☐	
	Glaucoma	☐	☐	
	Gout	☐	☐	
	Gynecological Conditions (Endometriosis)	☐	☐	
	Gynecological Conditions (Fibroids)	☐	☐	
	Gynecological Conditions (Other)	☐	☐	Type?
	Heart Attack	☐	☐	
	Hepatitis	☐	☐	Type?
	High Blood Pressure	☐	☐	
	High Cholesterol	☐	☐	
	Irritable Bowel Syndrome	☐	☐	
	Kidney Disease / Failure	☐	☐	
	Kidney Stones	☐	☐	
	Liver Disease	☐	☐	
	Migraine Headaches	☐	☐	
	Osteoporosis	☐	☐	
	Pneumonia	☐	☐	
	Prostate (enlargement)	☐	☐	
	Prostate (nodules)	☐	☐	
	Seizure / Epilepsy	☐	☐	
	Skin Condition (Eczema)	☐	☐	
	Skin Condition (Psoriasis)	☐	☐	
	Skin Condition (Other)	☐	☐	Type?
	Sleep Apnea	☐	☐	
	Stomach Ulcer	☐	☐	
	Stroke	☐	☐	
	Thyroid (nodule)	☐	☐	
	Thyroid High / Hyperthyroidism	☐	☐	
	Thyroid Low / Hypothyroidism	☐	☐	
	Other (List)	☐	☐	
	Other (List)	☐	☐	

SURGICAL HISTORY	Have you had any of the following surgeries or procedures?			☐ **No history of medical procedures or surgeries**
	Surgical Procedure	**Yes**	**Year**	**Comments**
	Abdominal surgery	☐		
	Angiogram (heart)	☐		
	Angiogram (vascular)	☐		
	Appendectomy (appendix removed)	☐		
	Back surgery (lumbar)	☐		
	Biopsy (location in comments)	☐		
	Breast biopsy	☐		Right ☐ Left ☐ Both ☐
	Breast surgery	☐		Right ☐ Left ☐ Both ☐
	Cataract surgery	☐		
	Colonoscopy	☐		
	Coronary bypass	☐		
	Coronary stent	☐		
	C-Section	☐		
	Echocardiogram (heart)	☐		
	EGD (stomach endoscopy)	☐		
	Gallbladder removal	☐		

Please go to next page

Surgical History continued

Surgical Procedure	Yes	Year	Comments
Heart surgery (other than coronary bypass above)	☐		
Hip surgery	☐		Right ☐ Left ☐ Both ☐
Hysterectomy (partial, ovaries left)	☐		Laparoscopic ☐ Vaginal ☐ Abdominal ☐
Hysterectomy (total, including ovaries)	☐		Laparoscopic ☐ Vaginal ☐ Abdominal ☐
Knee surgery	☐		Right ☐ Left ☐ Both ☐
LEEP (cervix surgery)	☐		
Neck (spine) surgery	☐		
Ovary removal	☐		Right ☐ Left ☐ Both ☐
Pulmonary function test	☐		
Sigmoidoscopy	☐		
Sinus surgery	☐		
Stress test (stress echo)	☐		
Stress test (thallium/perfusion)	☐		
Stress test (treadmill)	☐		
Tonsillectomy	☐		
Tubal ligation	☐		
Vasectomy	☐		
Other (list)	☐		
Other (list)	☐		

SOCIAL HISTORY

HEALTH ISSUES

Tobacco Use:

Smoke or smoke: ☐ Never ☐ Yes

Exposure to second-hand smoke? ☐ No ☐ Yes

(If never used any tobacco can skip to Alcohol Use section below)

Current smoker: Packs/day: _________ # of years: _________

Former smoker: Quit date: _________

Approximately how many packs/day did you smoke? ________

How many years did you smoke? _________

Other tobacco? Snuff Chew

Quite date _________ Currently use? ☐ Yes

Are you ready to quit? ☐ No ☐ Yes

Sexual Activity:

Are you sexually involved: ☐Not Currently ☐ Never ☐ Yes

Sexual partner(s) is/are/have been/may be in the future:
☐ Male ☐ Female

Birth control method or STD prevention (check all that apply):

☐ None needed ☐ Condom ☐ Pill ☐ IUD ☐ Patch ☐ Ring

☐ Diaphragm ☐ Vasectomy ☐ Tubal ligation

☐ Other method (specify): ___________________________

Alcohol Use:

Do you drink alcohol? ☐ No ☐ Yes

# of drinks/week: _________ ☐ Beer ☐ Wine ☐Liquor

How many times in a year have you had >3 drinks (for women)
or >4 drinks (for men) in a day? ____________

Diet & Exercise:

Do you follow a special diet? ☐ No ☐ Yes

vegetarian, vegan, gluten free, other ______________________

Do you exercise regularly? ☐ No ☐ Yes

If yes, what kind of exercise? _____________________________

How long (minutes)? _________ How often? ________________

In the past 2 weeks: Have you been feeling down, depressed, or hopeless? ☐ No ☐ Yes

Do you have little interest or pleasure in doing things?
☐ No ☐ Yes

Drug Use:

Have you **ever** used recreational drugs? ☐ No ☐ Yes

If yes, which ones? _____________________________________

Quit which ones? ☐ All _________________________________

Any used currently? ____________________________________

Other:

Military Service?	☐ No	☐ Yes
Blood Transfusion?	☐ No	☐ Yes
Exposure to toxic chemicals at work?	☐ No	☐ Yes
Exposure to toxic chemicals doing hobbies?	☐ No	☐ Yes

Number of children: ______

Education: ☐ high school or GED ☐ trade school ☐ college
☐ graduate school ☐ other ______________________________

Please go to next page

FAMILY HISTORY

Adopted? ☐ No ☐ Yes If adopted and you do **not** know your family history, skip the Family History section.

Indicate which relative has had the following diseases:

Diseases & Conditions	**Mother**	**Father**	**Sister(s)**	**Brother(s)**	**Mom’ s Mom**	**Mom’ s Dad**	**Dad’ s Mom**	**Dad’ s Dad**	**Other blood relatives (list relationship to you)**	**List age(s) at diagnosis if known and if this was the cause of death**
No significant history known	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hypertension-high blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hyperlipidemia-high cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Heart attack, Angina	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes Type II (adult onset)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer, Breast	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer, Colon	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer, Prostate	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Alcoholism / Drug abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Alzheimer’s	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Bleeding or Clotting Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer, Lung	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer, Ovarian	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer, Other type	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Colon Polyp	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes Type I (childhood onset)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Emphysema (COPD)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Genetic Disorder (explain)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Disease (CHF)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Disease (Other)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hepatitis B or C	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hip Fracture	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hypothyroidism/Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Kidney Stones	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sudden Cardiac Death	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other (list)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other (list)	☐	☐	☐	☐	☐	☐	☐	☐	☐	

OTHER

WOMEN’S HEALTH HISTORY

Total number of pregnancies: _________

Number of births: _________

Number of miscarriages: _________

Number of abortions: _________

Age at beginning of periods (menstruation): _________

Age at end of periods (menopause/hysterectomy): _________

Do you have concerns about your periods or menopause you would like to discuss? ☐ No ☐ Yes

If you are having periods, how often do they occur?

Every _________ days. How long do they last? ________ days.

MEDICAL FORMS

Please check any of the following forms you have completed:

☐ Advance Directive for Health Care
☐ Durable Power of Attorney for healthcare decisions
☐ Living Will
☐ Out of Hospital Do Not Resuscitate (OOHDNR)
☐ Know about these or have the forms but have not completed them
☐ Don’t know what these are

Please provide a copy of any forms you have completed

Thank you for taking the time to complete this form!