FHA Patient History Form - Age 19 and over

Name ____________________ **Date**_____/_____/_____ **Birth date**_____/_____/_____ **Gender** F M

Age__________ **Occupation**______________________________ **Marital Status:** S M D W

Personal Medical History (add details to the right)

Yes	No		Yes	No		Yes	No		Details
❑	❑	Alcoholism	❑	❑	Emphysema	❑	❑	Migraines	
❑	❑	Anemia	❑	❑	Erectile Dysfunction	❑	❑	Mult. Sclerosis	
❑	❑	Angina	❑	❑	Gastric Reflux	❑	❑	Osteoporosis	
❑	❑	Arthritis	❑	❑	Glaucoma	❑	❑	Pacemaker	
❑	❑	Asthma	❑	❑	Gout	❑	❑	PAP - abnormal	
❑	❑	Anxiety	❑	❑	Heart Disease	❑	❑	Pneumonia	
❑	❑	Blood Disorder	❑	❑	Headaches	❑	❑	Prostate Problems	
❑	❑	Bulimia	❑	❑	Hernia	❑	❑	STD	
❑	❑	Cancer	❑	❑	Herpes	❑	❑	Stroke	
❑	❑	Cataracts	❑	❑	Hepatitis	❑	❑	Suicide Attempt	
❑	❑	Chemical Dependency	❑	❑	Hypertension	❑	❑	Thyroid Problems	
❑	❑	Chronic Pain	❑	❑	High Chol	❑	❑	Tuberculosis	
❑	❑	Depression	❑	❑	HIV Positive	❑	❑	Urinary or kidney	
❑	❑	Diabetes	❑	❑	Liver Disease	❑	❑	Vaginal Infections	
❑	❑	Drug Addiction	❑	❑	Menstrual Problems	❑	❑		

Medical History - Other

____

____

Medications Allergies/Intolerances-List names & what happens **Latex Allergy** ❑**Yes** ❑**No**

If no allergies check this box ❑

______________ ______________ ______________

______________ ______________ ______________

Form of Birth Control ____________________ Vasectomy ❑ Yes ❑ No

Please list all Medications you are on, including vitamins, herbal supplements & birth control.

Medication name ~ Dose (e.g. mg/pill) ~ How many times per day?

1 ______________ 7 ______________

2 ______________ 8 ______________

3 ______________ 9 ______________

4 ______________ 10 ______________

5 ______________ 11 ______________

6 ______________ 12 ______________

Antibiotics - Recent antibiotic use in the last 6 months. Antibiotic name______________________________

Antibiotic was prescribed for______________________________

Family Medical History

Blood Relative	Alive	Age	Illness or Cause of Death	Blood Relative	Alive	Age	Illness of Cause of Death
Mother	❑Yes❑No			Sibling	❑Yes❑No		
Grandmother	❑Yes❑No			Sibling	❑Yes❑No		
Grandfather	❑Yes❑No			Children	❑Yes❑No		
Father	❑Yes❑No			Children	❑Yes❑No		
Grandmother	❑Yes❑No			Step-Child	❑Yes❑No		
Grandfather	❑Yes❑No			Other	❑Yes❑No		

Adult Immunizations

Description	Date	Date	Date	Date
Tetanus				
T-Dap (Adacel)				
Pneumovax				
Hepatitis B	1st	2nd	3rd	
Hepatitis A	1st	2nd		
Influenza (flu)				
Varicella				
Gardasil				
Zostavax				

Hospitalizations / Surgeries (Please include year)

Pregnancies / Deliveries (Please include year & gender)

Health Habits

Do you use tobacco products?
❑ Past ❑ Now ❑ Never

How much per day? _____Packs_____Cans_____Cigars_____Pipe

Are you exposed to second hand smoke at home?
❑ Past ❑ Now ❑ Never

Do you use alcohol?
❑ Past ❑ Now ❑ Never Number of drinks per week_____

Use caffeine, tea, soda? (Caffeinated)
❑ Past ❑ Now ❑ Never Number per day_____

If you ride a bike or motorcycle, do you wear a helmet? ❑Yes ❑No

Do you have a gun? ❑ Yes ❑ No

Do you practice gun safety? ❑ Yes ❑ No

Are you satisfied with your weight? ❑ Yes ❑ No

Any history of abuse?
❑ Mental ❑ Physical ❑ Sexual ❑ Emotional

Review of Systems (new or ongoing)

Please check "Past" or "Now". Do you now or have you ever had any problems related to the following. If yes, describe.

Past/ Now	Description	If now, describe
Constitutional Symptoms		
❑ / ❑	Fever	
❑ / ❑	Chills	
❑ / ❑	Headache	
Eyes		
❑ / ❑	Blurred Vision	
❑ / ❑	Double Vision	
❑ / ❑	Pain	
❑ / ❑	Vision Change	
❑ / ❑	Cataracts/Glaucoma	
❑ / ❑	Glasses/Contacts	
Allergic / Immunologic		
❑ / ❑	Hay Fever	
❑ / ❑	Drug Allergies	
Neurological		
❑ / ❑	Tremors	
❑ / ❑	Dizzy Spells	
❑ / ❑	Numbness/Tingling	
Endocrine		
❑ / ❑	Excessive Thirst	
❑ / ❑	Too Hot/Too Cold	
❑ / ❑	Tired/Sluggish	
Gastrointestinal		
❑ / ❑	Weight Loss	
❑ / ❑	Abdominal Pain	
❑ / ❑	Nausea/Vomiting	
❑ / ❑	Indigestion/Heartburn	
Cardiovascular		
❑ / ❑	Chest Pain	
❑ / ❑	Varicose Veins	
❑ / ❑	High Blood Pressure	

Past / Now	Description	If now, describe
Skin		
❑ / ❑	Skin Rash	
❑ / ❑	Boils	
❑ / ❑	Persistent Itch	
❑ / ❑	Skin / Breast	
Musculoskeletal		
❑ / ❑	Joint Pain	
❑ / ❑	Fractures	
❑ / ❑	Other	
Ear / Nose Throat / Mouth		
❑ / ❑	Ear Infection	
❑ / ❑	Sore Throat	
❑ / ❑	Sinus Problems	
Genitourinary		
❑ / ❑	Erectile Dysfunction	
❑ / ❑	Painful Urination/Urine r	
❑ / ❑	Urinary Frequency	
Respiratory		
❑ / ❑	Wheezing	
❑ / ❑	Frequent Cough	
❑ / ❑	Shortness of Breath	
Hematologic / Lymphatic		
❑ / ❑	Swollen Glands	
❑ / ❑	Blood Clotting Problem	
Psychologic		
❑ / ❑	Are you generally satisfied with your life?	
❑ / ❑	Do you feel severely depressed or anxious?	
❑ / ❑	Are you feeling suicidal?	

Comments:

Health Care Maintenance: **Please list when you last had the following tests, date, age, location and result if known:**

Test	Date	Result
Physical Exam		
Stool for Blood		
Colonoscopies		
Cholesterol (most recent)		
Eye Exam/Vision Test		
Hearing Test		
Dental Exam (most recent)		

For Women **Do you perform regular (monthly) self-breast exams? ❑ Yes ❑ No**

Test	Date	Result
Breast Exam by Provider		
Mammogram		
PAP Smear/Pelvic Exam		

For Men: **Do you perform regular (monthly) self - testicle exams? ❑ Yes ❑ No**

Test	Date	Result
Prostate/Testicle Exam		
PSA Blood Test		