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| **FCHC - PATIENT HEALTH HISTORY FORM****PLEASE COMPLETE IN BLACK INK** | TODAY’S DATE PAGE 1 |
| LAST NAME | LEGAL FIRST NAME | MI | DATE OF BIRTH |
| **YOUR HEALTH HISTORY** |
| **Check all items either****No or Yes** | **No** | **Yes, Now** | **Yes, Past** | **Check all items either** **No or Yes** | **No** | **Yes, Now** | **Yes, Past** | **Check all items either** **No or Yes** | **No** | **Yes, Now** | **Yes, Past** |
| **CARDIOVASCULAR** | **EYES** | **INTEGUMENTARY/SKIN** |
| Drug Allergies |  |  |  | Blurred Vision |  |  |  | Boils/Lesions |  |  |  |
| Hay Fever |  |  |  | Double Vision |  |  |  | Persistent Itch |  |  |  |
| Latex Allergy |  |  |  | Eye Pain |  |  |  | Skin Rash |  |  |  |
| High Blood Pressure |  |  |  | Failing Vision |  |  |  | **MUSCULOSKELETAL** |
| Low Blood Pressure |  |  |  | Vision Loss |  |  |  | Back Pain |  |  |  |
| Palpitations |  |  |  | **GASTROINTESTINAL** | History of Falls |  |  |  |
| Varicose Veins |  |  |  | Abdominal Pain |  |  |  | History of Fractures |  |  |  |
| **CONSTITUTIONAL** | Appetite Loss |  |  |  | Joint Pain |  |  |  |
| Chills |  |  |  | Blood in Stool |  |  |  | Neck Pain |  |  |  |
| Fatigue or Weakness |  |  |  | Constipation |  |  |  | **NEUROLOGICAL** |
| Fever |  |  |  | Diarrhea |  |  |  | Dizzy Spells |  |  |  |
| Headache (Frequent) |  |  |  | GI Bleed |  |  |  | Memory Loss |  |  |  |
| Weight Gain |  |  |  | Indigestion/Heartburn |  |  |  | Numbness/Tingling |  |  |  |
| Weight Loss |  |  |  | Nausea/Vomiting |  |  |  | Seizures |  |  |  |
| **EAR/NOSE/THROAT** | Ulcers/Reflux/GERD |  |  |  | Stroke |  |  |  |
| Difficulty Hearing |  |  |  | **GENITOURINARY** | Tremors |  |  |  |
| Ear Infections |  |  |  | Bladder Leakage |  |  |  | **PSYCHIATRIC** |
| Ringing Ears |  |  |  | Blood in Urine |  |  |  | Anxiety |  |  |  |
| Sinus Trouble |  |  |  | Painful Urination |  |  |  | Depression |  |  |  |
| Sore Throat |  |  |  | Urinary Frequency |  |  |  | Difficulty Sleeping |  |  |  |
| **ENDOCRINE** | Urine Retention |  |  |  | **RESPIRATORY** |
| Cold Intolerance |  |  |  | **HEMATOLOGIC/LYMPHATIC** | Difficulty Breathing |  |  |  |
| Excessive Thirst |  |  |  | Abnormal Bleeding |  |  |  | Frequent Cough |  |  |  |
| Heat Intolerance |  |  |  | Bleeding Disorders |  |  |  | History/Exposure TB |  |  |  |
| Thyroid Trouble |  |  |  | Blood Clotting Problems |  |  |  | Shortness of Breath |  |  |  |
| Tired/Sluggish |  |  |  | Swollen Glands |  |  |  | Wheezing |  |  |  |
| **HABITS/SOCIAL HISTORY** | **MEDICATIONS** |
| **Do you:** | **No** | **Yes** | **If Yes, how much?** | Please list all medications you are now taking, including those you buy without a doctor’s prescription (over-the-counter, supplements, herbals, etc.)  |
| Smoke Tobacco |  |  | Packs/Day |
| Chew Tobacco |  |  | Tins or Bags/Day |
| **Did you Smoke?** |  |  | Year Quit | **What pharmacy do you use?** |  |
|  How many years did you smoke? | Packs/Day | **Medication** | **Dosage** | **How many times a day?** |
| Drink Alcohol or Wine |  |  | Drinks/Day |  |  |  |
| Drink Beer |  |  | Cans/Day |  |  |  |
| Drink Caffeine |  |  | Cups/Day |  |  |  |
| Use Recreational Drugs |  |  |  |  |  |  |
| Exercise |  |  |  |  |  |  |
| Live Alone |  |  |  |  |  |  |
| History of Falls |  |  |  |  |  |  |
| History of Fractures |  |  |  |  |  |  |
| **IMMUNIZATIONS** | **ALLERGIES** |
|  | **No** | **Yes** | **Date** |  | **No** | **Yes** | **Reaction** |
| Flu Shot |  |  |  | Aspirin |  |  |  |
| Hepatitis B |  |  |  | Banana |  |  |  |
| MMR |  |  |  | Bee Sting |  |  |  |
| Pertussis (Whooping Cough) |  |  |  | Codeine |  |  |  |
| Drug |  |  |  |
| Pneumonia |  |  |  | Hay Fever |  |  |  |
| Tetanus |  |  |  | Latex |  |  |  |
| Zoster (Shingles) |  |  |  | Peanuts |  |  |  |
| **SPIRITUAL/RELIGIOUS PRACTICES** | Penicillin |  |  |  |
|  | **No** | **Yes** | **Explanation** | Shellfish |  |  |  |
| Are there any spiritual/ religious practices or restrictions we should know about in providing your medical care? |  |  |  | Sulfa |  |  |  |
|  | Other |  |  |  |
|  |  |  |  |  |
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| **FCHC - PATIENT HEALTH HISTORY FORM****PLEASE COMPLETE IN BLACK INK** | TODAY’S DATE PAGE 2 |
| LAST NAME | LEGAL FIRST NAME | MI | DATE OF BIRTH |
| **Are you being treated by other Healthcare Professionals?** No Yes **If yes, please list doctors & reasons for treatment.**Physician/SpecialistDentistChiropractor |
| **HOSPITALIZATIONS** **(NOT INCLUDING NORMAL PREGNANCIES)** | **SERIOUS ILLNESS** **(NOT REQUIRING HOSPITALIZATION)** |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
| **PAST SURGERIES** | **PAST ACCIDENTS** |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
| **FAMILY HISTORY** |
|  | **Living** | **Deceased** | Year of Birth | Age | Hypertension | Diabetes | Heart Disease | Stroke | Mental Illness | Cancer: List Type | Other Health Issue: List |
| Father |  |  |  |  |  |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |  |  |  |  |  |
| Father’s Father |  |  |  |  |  |  |  |  |  |  |  |
| Father’s Mother |  |  |  |  |  |  |  |  |  |  |  |
| Mother’s Father |  |  |  |  |  |  |  |  |  |  |  |
| Mother’s Mother |  |  |  |  |  |  |  |  |  |  |  |
| Son(s) |  |  |  |  |  |  |  |  |  |  |  |
| Daughter(s) |  |  |  |  |  |  |  |  |  |  |  |
| Siblings: |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |
| Spouse |  |  |  |  |  |  |  |  |  |  |  |
| **OTHER INFORMATION** | **WOMEN ONLY** |
|  | **No** | **Yes** |  | **No** | **Yes** |
| Last Colonoscopy? |  | Abnormal? |  |  | Last Pap Smear? |  | Abnormal? |  |  |
| Last Sigmoidoscopy |  | Abnormal? |  |  | Last Mammogram? |  | Abnormal? |  |  |
| Last Hema-Chek? |  | Abnormal? |  |  | Age Periods Started? |  | Problems? |  |  |
| Wake in the night to go to the bathroom? |  |  | Ovarian Cysts? |  |  |
| Are you currently sexually active? |  |  | Vaginal itching, burning or discharge? |  |  |
| Sexual Problems or concerns? |  |  | Breast lumps, disease or nipple discharge? |  |  |
| Do you feel safe in your home? |  |  | Pregnant Now? |  |  |
| Do you have a Living Will? |  |  | Planning a Pregnancy? |  |  |
|  If Yes, where is it? | Nursing a Child? |  |  |
|  If No, would you like information on Living Wills? |  |  | Pregnancies | # | Births | # |
| Have you ever been treated for alcohol abuse? |  |  | Miscarriages | # | Abortions | # |
| Have you ever been treated for drug abuse? |  |  | Birth Control Method |
| Do you currently abuse any substances? |  |  |  |  |  |
| Are you under a lot of pressure/stress at work? |  |  | **MEN ONLY** |
| Are you under a lot of pressure/stress at home? |  |  |  | **No** | **Yes** |
| Have you ever had anesthesia? |  |  | Last PSA? |  | Abnormal? |  |  |
|  If Yes, did you have any problems? | Last Prostate Exam? |  | Abnormal? |  |  |
| Are you on a special diet? |  |  | Pain or lump(s) in testicles? |  |  |
| Are you on any food restrictions? |  |  | Penile (penis) itching, burning or discharge? |  |  |
|  If Yes, specify | Prostate Disease or problems? |  |  |
| Have you had a blood transfusion in the past 6 months? |  |  | Problems starting or stopping your urine stream? |  |  |

The information on this Patient Health History Form is correct to the best of my knowledge.

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PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE