extant healthcare

Today's Date: ____/___/____

Chart #_____

Health History Questionnaire

Name: _____ Birth Date: ____/____/_____ Gender: M or F

Ethnicity: _____Preferred Language: _____Reason for visit: _____

Primary Care Physician: _____ Occupation: _____

REVIEW OF SYSTEMS (CIRCLE ANY SYMPTOMS YOU ARE EXPERIENCING NOW)

GENERAL: Chills, Fatigue, Fever, Night Sweats, Weight Loss

SKIN: Bruising, Hives, Rash

HEENT: Blurred vision, Double vision, Vision loss, Hoarseness, Sore throat

RESPIRATORY: Bloody sputum (cough), Cough, Difficulty breathing (shortness of breath), Wheezing, Waking up from sleep wheezing or short of breath.

CARDIOVASCULAR: Chest pain, Leg cramps, Leg pain and/or swelling (or foot pain at rest), Palpitations, Swelling of extremities

GASTROINTESTINAL: Abdominal pain, Bloody stool, Change in bowel habits (change in stool caliber or color), Constipation, Diarrhea, Food intolerance (no appetite), Nausea, Vomiting blood

FEMALE: Excessive menstrual bleeding, Menstrual irregularities, Vaginal bleeding

GENITOURINARY: blood in urine, Difficulty emptying bladder, Painful urination, Urinating at night

MUSULOSKELETAL: Back pain, Joint pain (aches), Muscle cramps, Muscle pain (aches)

NEUROLOGICAL: Difficulty speaking, Headaches, Numbness, Trouble walking (or limited ability to walk), Weakness in extremities (of arms or legs)

PSYCHIATRIC: Anxiety, Depression, (sadness hopelessness), Memory loss

ENDOCRINE: Cold intolerance: Excessive thirst, Excessive urination, Heat intolerance

HEMOTOLOGY: Gland problems (swelling lymph glands)

Surgery History ☐ **No Previous Surgeries**

Procedure	Date/Year	Hospital/Doctor Performing	Results

Medications ☐ **No Medications**

Name	Dose	Frequency	Reason

Allergies ☐ **No Known Drug Allergies**

Name	Reaction	Treatment

Past Medical History

☐ **No Medical Problems**

Cardiovascular
☐Angina
☐Heart Murmur
☐Valve Disorder
☐Heart Attack
☐Atrial Fibrillation/Flutter
☐Other Arrhythmia
☐High Blood Pressure
☐Congestive Heart Failure
☐Peripheral Vascular Disease
☐High Cholesterol
☐Pacemaker/Defibrillator
☐Cardiac Stents
☐Bypass surgery

Lung
☐Asthma
☐Emphysema
☐COPD
☐ Sleep Apnea
☐Lung Cancer
☐TB

Breast
☐Nipple Discharge
☐Fibrocystic Disease
☐Abnormal Mammogram
☐Breast Cancer

Abdomen/GI
☐Diverticular Disease
☐Ulcerative Colitis
☐Crohn's Disease
☐Gallstones
☐Hepatitis
☐Cirrhosis
☐GERD/Reflux
☐Stomach Ulcer
☐Hemorrhoids
☐Intestinal Cancer

Endocrine
☐Diabetes
☐Thyroid Disorder
☐ Steroid Use

Psychiatric
☐Anxiety
☐Depression
☐ ADD/ADHD

Hematologic/Immune
☐Anemia
☐ Bleeding disorder
☐ Clotting disorder
☐Pulmonary Embolus
☐DVT
☐HIV/AIDS

Gynecologic
☐Fibroids
☐Ovarian Cysts
☐Endometriosis
☐Abnormal Bleeding
☐Cancer
☐C-section

Urinary System
☐Kidneys Stones
☐Chronic Renal Failure
☐ Dialysis
☐Frequent UTI
☐Enlarged Prostate
☐Prostate Cancer

Orthopedic
☐Fracture
☐Artificial Joint
☐Arthritis
☐Osteoporosis
☐Gout

Neurologic
☐Stroke
☐Seizure Disorder
☐Brian bleed
☐Migraines
☐Other Headaches

Skin
☐Cancer (non-melanoma)
☐Melanoma

Eye
☐Glaucoma
☐Glasses/Contacts
☐Blindness

Family Medical History

☐ **No Family Medical Problems**

Condition	**Relation**
☐Breast Cancer	_____
☐Colon Cancer	_____
☐Prostate Cancer	_____
☐Ovarian Cancer	_____
☐Heart Disease/Heart Attack	_____
☐Stroke	_____
☐High Blood Pressure	_____
☐Gallbladder Disease	_____
☐Diabetes	_____
☐Other Cancer	_____
☐Other Medical Problems	_____

Other Physicians
Primary Care Physician _____
Gastroenterology _____
Cardiology _____
Pulmonary _____
Nephrology _____
Neurosurgery _____
Orthopedic Surgery _____
Plastic Surgery _____

Social History

Have you smoked? ☐Yes ☐No
Do you currently Smoke? ☐ Yes ☐No
How many years? _____
How many packs per day? _____
When did you quit? _____
Other tobacco use? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No
Number of drinks per week ____
☐Beer
☐Wine
☐Liquor
History of alcohol abuse? ☐Yes ☐No

Have you ever used drugs? ☐Yes ☐No
☐Marijuana Other: _____
☐Cocaine
☐Heroin
☐Prescriptions Opiates

Office Use Only

Height: _____ Weight: _____ Temp: _____ BP: _____ Pulse: _____ Sat:_____