

# Duluth Family Practice Center

## Patient Health History Form

Label

<b>Name</b>				<b>Today's Date</b>			
<b>Gender (Sex)</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<b>Age</b>	<b>Birth Date</b> (mm/dd/yyyy)			
<b>Marital Status</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed		
<b>Currently Living</b>	<input type="checkbox"/> Alone	<input type="checkbox"/> With Family	<input type="checkbox"/> With Friends	<input type="checkbox"/> With Significant Other			
<b>Profession (Job)</b>	<input type="checkbox"/> Working, Employed By:						<input type="checkbox"/> Retired

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
Abnormal EKG				Headaches (Frequent)			
Alcoholism				Heart Attack or Heart Disease			
Anemia or Low Blood				Heart Murmur			
Anxiety				Hemorrhoids or Rectal Problems			
Arthritis or Sore Joints				Hepatitis Type A, B or C (circle)			
Asthma or Hay Fever				Hernia			
Bleeding or Bruising				High Blood Pressure			
Broken Bones				High Cholesterol			
Bronchitis or Emphysema				HIV/AIDS			
Cancer				Jaundice			
Cataracts				Kidney or Bladder Problems			
Chemical Dependency				Leg or Foot Pain			
Chest Pain				Liver Disease			
Circulation Problems				Night Sweats			
Deafness or Dizziness or Ringing Ears				Phlebitis or Blood Clots			
Depression or Sadness				Psychiatric Care			
Diabetes				Sexually Transmitted Disease			
Difficulty Sleeping or Lie Awake at Night				Shortness of Breath			
Ear Infections				Sinus Trouble			
Epilepsy or Seizures				Skin Disease or Psoriasis or Eczema			
Fatigue or Tiredness or Weakness				Stomach Problems or Ulcers			
Forgetful				Stool or Bowel Problems			
Gall Stones				Stroke			
Glaucoma				Thyroid Problem			
Gout				Tuberculosis or Positive TB Test			
Head Injury				Weight Loss or Gain (circle one)			

Habits			Medications	
<b>Do you:</b>		<b>If Yes, how much?</b>	<b>Please list all medications you are now taking, including those you buy without a doctor's prescription (over-the-counter, supplements, herbals, etc.)</b>	
Smoke Tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes	Packs/Day	1.	8.
Chew Tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tins or Bags/Day	2.	9.
Drink Caffeine	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cups/Day	3.	10.
Drink Alcohol or Wine	<input type="checkbox"/> No <input type="checkbox"/> Yes	Drinks/Day	4.	11.
Drink Beer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cans/Day	5.	12.
Gamble	<input type="checkbox"/> No <input type="checkbox"/> Yes		6.	13.
Use Street Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes		7.	14.
Exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes			

**Please Turn Over and Complete Other Side**

Immunizations			Allergies	
Flu Shot	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date	List anything that you are allergic to (medications, foods, bee sting, etc.) and how each affects you.	
Hepatitis B	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date		
MMR	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date		
Pneumonia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date		
Tetanus	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date		
			1.	Reaction:
			2.	Reaction:
			3.	Reaction:
			4.	Reaction:
			5.	Reaction:

Hospitalizations (not including normal pregnancies)		Serious Illness (not requiring hospitalization)	
1.	Year	1.	Year
2.	Year	2.	Year
3.	Year	3.	Year
4.	Year	4.	Year

Family History																			
<b>Check (v) either No or Yes. If Yes, please check (v) the family member who has (or in the past had) any of the medical problems listed.</b>		Father	Mother	Brother	Sister	Son	Daughter	Grandparent	<b>Check (v) either No or Yes. If Yes, please check (v) the family member who has (or in the past had) any of the medical problems listed.</b>				Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Alcoholism	<input type="checkbox"/> No <input type="checkbox"/> Yes								High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes									
Allergies	<input type="checkbox"/> No <input type="checkbox"/> Yes								Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes									
Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes								Leukemia	<input type="checkbox"/> No <input type="checkbox"/> Yes									
Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes								Liver Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes									
Asthma or Hay Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes								Mental Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes									
Birth Defects	<input type="checkbox"/> No <input type="checkbox"/> Yes								Migraines	<input type="checkbox"/> No <input type="checkbox"/> Yes									
Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes								Nervous Breakdown	<input type="checkbox"/> No <input type="checkbox"/> Yes									
Colon or Bowel Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes								Obesity	<input type="checkbox"/> No <input type="checkbox"/> Yes									
Congenital Heart Defects	<input type="checkbox"/> No <input type="checkbox"/> Yes								Rheumatic Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes									
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes								Sickle Cell Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes									
Emphysema	<input type="checkbox"/> No <input type="checkbox"/> Yes								Stomach Problems or Ulcer	<input type="checkbox"/> No <input type="checkbox"/> Yes									
Epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes								Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes									

Men Only				Women Only			
Pain or lump(s) in testicles?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Last Pap Smear		Abnormal? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Penile (penis) itching, burning or discharge?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Last Mammogram		Abnormal? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Prostate disease or problems?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Age Periods Started		Problems? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Problems starting or stopping your urine stream?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Ovarian Cysts		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Wake in the night to go to the bathroom?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Sexual problems or concerns?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Sexual problems or concerns?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Vaginal itching, burning or discharge?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you feel safe in your home?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Wake in the night to go to the bathroom?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a Living Will? <input type="checkbox"/> No <input type="checkbox"/> Yes		Where?		Breast disease or nipple discharge?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
If No, would you like information on Living Wills?		<input type="checkbox"/> No <input type="checkbox"/> Yes		Pregnancies #		Births #	
				Miscarriages #		Abortions #	
				Birth Control Method:			
				Do you feel safe in your home?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
				Do you have a Living Will? <input type="checkbox"/> No <input type="checkbox"/> Yes		Where?	
				If No, would you like information on Living Wills?		<input type="checkbox"/> No <input type="checkbox"/> Yes	

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

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_