HEALTH HISTORY FORM

PRINT NAME ______________________________ DATE OF BIRTH _______________ DATE ___________

You are scheduled for a "well-person visit" today. This visit is designed to discuss ways to keep you healthy. Evaluation and management of medical problems must be billed to your insurance separately as a "sick visit" A sick visit may not be covered by your insurance if those medical problems are addressed on the same day as your well person visit. If your insurance does not cover the sick visit, then you will be responsible for paying for that visit. **If you have any new health concerns or any of the symptoms listed below, please let your physician know so that the two of you can decide what is important to address during your visit.**

Since your last visit,

1. Do you have any new medications, serious illnesses, surgeries, or hospitalizations? YES NO
2. Has anyone in your immediate family been diagnosed with a new serious health problem? YES NO
   (Heart disease, cancer-colon, breast, prostate, diabetes, glaucoma, etc.)
3. Has there been any change in your living situation YES NO
   (Marriage/divorce, children, move, change of job)?

Last dental exam: ___________________________________ Last vision exam: ___________________________________

Frequency/amount of alcohol use: _____________________Frequency/amount of tobacco use: _____________________

Frequency/amount of drug use: _______________________Frequency/amount of exercise: _________________________

Review of Systems: Please indicate if you are currently having problems in the areas listed below that are interfering with your daily life; if yes, please explain:

- Constitutional: Are you having problems with your weight, fever, fatigue? YES NO
- Eyes: Are you having problems with your eyes or vision? YES NO
- Ear/Nose/Throat: Are you having problems with hearing or sinuses? YES NO
- Cardiovascular: Are you having any chest pain, trouble breathing or leg swelling? YES NO
- Respiratory: Are you having wheezing or a cough? YES NO
- Gastrointestinal: Are you having problems with your stomach or bowels? YES NO
- Genitourinary: Are you having problems with urination, sexual function or menstruation (women)? YES NO
- Musculoskeletal: Are you having any problems with your muscles or joints? YES NO
- Integumentary: Any problems with your skin or breast? YES NO
- Neurological: Any headaches, numbness, or tingling? YES NO
- Psychiatric: Are you having any problems with your mood or with sleeping? YES NO
  - Over the past two weeks have been bothered by little interest or pleasure in doing things? YES NO
  - Over the past two weeks have you been bothered by feeling down, depressed, or hopeless? YES NO
- Endocrine: Are you more thirsty or hungry than usual? YES NO
- Hematologic/Lymphatic: Are you having abnormal bleeding or swollen glands? YES NO
- Do you have an advanced directive and medical power of attorney? YES NO

Patient Signature __________________________________Date___________ Reviewed By: ___________Date: ________