Initial Heath History Form

Lisa Davis, M.D., F.A.C.P.

Name _____

Date of Birth_____

Date _____

What is the reason for your initial appointment?_____

Who referred you? _____

Personal Medical History

Please circle any of the following that you have been diagnosed with:

Diabetes High Blood Pressure High Cholesterol Heart Attack

Heart Murmur Atrial Fibrillation Aneurysm Rheumatic Fever

Congestive Heart Failure PAD Blood Clot in legs or lungs

Circulation Problems

Kidney Disease Kidney Stones Recurrent Urine Infections

Enlarged Prostate Erectile Dysfunction Prostate Cancer

Hepatitis A B or C Cirrhosis Liver Disease

Cancer Type_____ Year _____

Thyroid Disease. Adrenal Gland Disorder Parathyroid Adenoma

Depression Bipolar Anxiety / Panic Attacks Other Mental Illness

Suicide Attempt

Peptic Ulcer. Reflux. Hiatal Hernia. Colon Polyps. Ulcerative Colitis

Crohn's Irritable Bowel. Hemorrhoids

Osteoporosis Osteoarthritis Rheumatoid Arthritis Lupus. Gout

Fibromyalgia Chronic Pain. Herniated Disc. Neck Problems

Migraine Headaches Tension Headaches Seizures

Acne. Psoriasis Eczema. Rosacea. Other Skin Disorders

Sleep Apnea. Asthma. COPD/ Emphysema Bronchitis. Pneumonia

Anemia. Leukemia Blood Clotting Disorder

TB. HIV. MRSA. Syphilis Gonorrhea. VD

Neuropathy. Nerve Damage. Multiple Sclerosis. Stroke

Dementia. Alzheimer's Parkinson's

Glaucoma Retinopathy

Any other major or chronic medical problems please list:

Ever Have Any Blood Transfusions YES. NO

Please Circle Surgeries:

Heart Bypass. Leg Bypass Valve Replacement. Pacemaker

Heart stent Carotid Heat Cath

Appendix. Gallbladder Tonsils

Prostate

Tubal Ligation. C section Hysterectomy

Back Hip. Knee

Thyroid Hernia. Abscess. Cosmetic Surgery

List any other surgeries:

List All Hospitalizations and approximate date:

Allergies to medications and what was the reaction:

BRING ALL BOTTLES Of CURRENT MEDICATIONS
If you do not have please list

List names of Specialists and what they are treating you for:

Preventative Care:

List date of Vaccines:

Flu____
Pneumonia____
Tetanus____
Shingles____
MMR_____
Chicken Pox____
Hepatitis B_____
Gardasil_____

Date of last Colonoscopy_____

Men: Date of last PSA_____ Rectal Exam_____

Women : Date of last Pap_____ Mammogram_____
DEXA_____

Family Medical History:

Circle if any of your blood relatives have:

Diabetes. Premature Heart Disease High Blood Pressure

Aneurysms Kidney Failure Depression Alcoholism

Blood clots Bleeding Disorder. Thyroid Disease

Cancer of Breast. Colon. Ovaries

Heath History of

Mother living well age _____ has history of_____
died age _____ from_____

Father living well age _____ has history of_____
died age _____ from_____

Heath status or cause of death of brothers and sisters:

Social History:

What kind of work do you do?_____

If retired, from what?_____

If disable , disabled due to_____

Who do you live with?_____

Please Circle all that apply:

Single Married. Widowed Divorced Significant Other

Smoker Ex-Smoker Non-smoker

History of drug abuse. IV Drug use Alcoholism

Tattoos Piercing Multiple sex partners

Education :

Did not finish High School
High School
Some College
College Degree in_____
Masters
PhD

Do you have a DNR or Living Will? Yes. No

May we contact you by email regarding results or appointments? Yes No
If yes , initial here_____

Email address _____

Review of Systems

Please circle any of the following that you have recently experienced:

General/Constitutional:

Weight loss or gain, loss of general state of health or sense of well-being, strength, ability to conduct usual activities, exercise intolerance

Skin:
Rash, itching, pigmentation, moisture or dryness, texture, changes in hair growth or loss, nail changes

Breast :
Breast lumps, tenderness, swelling, nipple discharge

Eyes/Ears/Nose/Mouth/Throat:
Headaches, vertigo, lightheadedness, injury
Vision, double vision, tearing, blind spots, pain
Nose bleeding, colds, obstruction, discharge
Dental difficulties, gingival bleeding, dentures
Neck stiffness, pain, tenderness, masses in thyroid or other areas
Loss of hearing , ringing in ears

Cardiovascular:
Chest pain, , palpitations, passing out, shortness of breath on exertion, shortness of breath at rest or laying down ,leg swelling hypertension, leg pain with walking relieved by rest , varicose veins

Respiratory:

Pain , shortness of breath, wheezing, cough, coughing up blood,, respiratory infections, tuberculosis (or exposure to tuberculosis), fever or night sweats

Gastrointestinal:
Appetite loss , indigestion, abdominal pain, heartburn, gas , nausea, vomiting, vomiting blood, jaundice, constipation, or diarrhea, abnormal stools (clay-colored, tarry, bloody, greasy, foul smelling), hemorrhoids, recent changes in bowel habits

Genitourinary:
Urgency, frequency, burning , urinating at night , blood in urine,urinating more than usual,unusual (or change in) color of urine, stones, infections, hesitancy, change in size of stream, dribbling, acute retention or incontinence, libido, potency, genital sores, discharge, venereal disease (Female) Age of onset of menses:
regularity, last period_____, heavy periods,pain with periods, bleeding between periods, vaginal discharge, post-menopausal bleeding, pain with intercourse, vaginal dryness

Musculoskeletal:

Pain, swelling, redness or heat of muscles or joints, limitation of motion, muscular weakness, cramps

Neurologic/Psychiatric

Convulsions, paralyses, tremor, incoordination, numbness ,tingling, difficulties with memory of speech, sensory or motor disturbances, or muscular coordination (ataxia, tremor)
Predominant mood "nervousness" emotional problems, anxiety, depression, previous psychiatric care, unusual perceptions, hallucinations

Stress at home, work , Loss of job, loved-one ,Recent move , divorce or separation

Allergic/Immunologic/Lymphatic/

Reactions to drugs, food, insects, skin rash, trouble breathing
Anemia, bleeding tendency, previous transfusions and reactions,
Rh incompatibility
Local or general lymph node enlargement or tenderness.

Endocrine :
Urinating a lot, sever thirst , lack of interest in sex, inability to achieve orgasm, erectile dysfunction intolerance to heat or cold

Thank you for completing this form