Patient Health Survey Worksheet

*Please complete the following forms in the comfort of your home **prior to your visit**, then bring them with you at the time of your visit. This will allow me to review your history. If these forms are not completed prior to arrival, you may be asked to reschedule your appointment.*

Name:______________________________________ **Age:**_______ **Male / Female** **D.O.B.:** ___/___/___

PMH: Past Medical History:

Instructions: Have **YOU** been personally diagnosed by a physician with any of the following **Medical Conditions**?

(Check off the **NO** or **YES** column)

FHx: Family History:

Have any of **YOUR RELATIVES** been diagnosed with the following **Medical Conditions**?
If they have, then indicate this in this **Relationship** column using the following codes.
GF = Grand Father
GM = Grand Mother
F = Father / M = Mother
B = Brother / S = Sister

ROS: Review Of Systems:

Do you have (or have you recently had) any of the following problems?

Medical Conditions:	NO	YES	Relationship
HEENT:			
Headaches			
Eye Injuries			
Macular Degeneration			
Cataracts			
Blindness			
Hearing Loss			
Vertigo			
Recurrent Sinusitis			
CV:			
Problems with vessels blocked			
Blood clots in your veins (DVT)			
Coronary artery disease			
Heart attacks			
Angina			
Abnormal Heart Rhythm________			
Cardiomyopathy			
High blood pressure			
High Cholesterol			
High Triglycerides			
Congestive heart failure			
Other______________			
PULM:			
Cystic Fibrosis			
Emphysema			
Chronic Bronchitis			
Asthma			
Sleep Apnea			
Tuberculosis			
Other__________			

ROS	NO	YES
Gen:		
Fever?		
Chills?		
Sweats?		
HEENT:		
Frequent or severe headaches?		
Visual changes?		
Hearing Changes?		
Frequent ringing in ears?		
Ear Pain?		
Oral or nasal sores or lumps?		
Recurrent nasal congestion?		
CV:		
Chest pain?		
Feeling like your heart is fluttering or racing?		
Wake, gasping for breath? __________		
Trouble breathing when lying flat?		
Swelling of your ankles?		
Cramps in legs while walking?		
Rapid increase in weight?		
PULM:		
Shortness of breath?		
Cough?		
Wheezing?		
Increased sputum production?		
Coughing up blood?		
Require home Oxygen?		
Been told that you snore loudly?		

PMH & FHx (cont.)	NO	YES	RELATIONSHIP
GI:			
Stomach Ulcers			
Gastro-esophageal Reflux (GERD)			
Hepatitis			
Pancreatitis			
Irritable bowel disease			
Ulcerative Colitis			
Crohn's Disease			
Diverticulosis			
Hemorrhoids			
Hernias__________			
Other___________			
Other___________			
GU:			
Kidney Failure			
Kidney Stones			
Recurrent urine infections			
Enlarged Prostate (BPH)			
History of any Sexually Transmitted Diseases?			
Urinary incontinence_______________			
Other________________			
Other			
GYN: (for women to fill out only)			
Uterine Fibroids (Leiomyoma)			
Tubal (ectopic) pregnancy			
Endometriosis			
Ovarian cyst or tumors			
Endometrial hyperplasia			
Cervical Dysplasia			
Fibrocystic Breasts			
Tumors of the breast			
Other________________			
ENDOCR:			
Diabetes			
Low sugar (HYPOglycemia)			
High Thyroid (Hyperthyroid)			
Low Thyroid (Hypothyroid)			
Other__________________			
HEME/ONC:			
Hemophilia			
Low blood (Anemia)			
Low platelets			
Cancer____________			
Other_____________			
MUSC./SKEL:			
Osteo-arthritis			
Rheumatoid Arthritis			
Lupus (SLE)			
Gout			
Fibromyalgia			
Brittle Bones (Osteoporosis)			
Bone or muscle injuries			
Other__________________			

ROS (cont.)	NO	YES
GI:		
Do you frequently have nausea or vomiting?		
Frequent Diarrhea?		
Difficulty swallowing?		
Pain when swallowing?		
Vomiting up blood or what looks like coffee grounds?		
Frequent heartburn?		
Abdominal pain?		
Black tarry stool?		
Blood in stool?		
GU:		
Burning when urinating?		
Have to urinate frequently?		
Sudden sever urges to urinate?		
Hesitation or dribbling urine stream?		
Waking at night to urinate?		
Blood in urine?		
Accidental leaking of urine?		
Discharge from genitals?		
Sores or lumps on genitals?		
Loss of sexual ability/drive/interest?		
GYN: (for women to fill out only)		
Last normal menstrual period (date)?		
Number of pregnancies in past?		
Number of child births?		
Number of abortions or miscarriages?		
Excessively painful periods?		
More than one period every 28 days?		
Vaginal discharge, lumps or sores?		
Breast pain, discharge lumps, dimpling or skin changes?		
ENDOCR:		
Frequent large amount of urination?		
Frequently thirsty?		
Unable to tolerate hot or cold temperature fluctuations?		
HEME/ONC:		
Difficulty stopping cuts from bleeding?		
Dizziness upon standing?		
Unexplainable weight loss?		
MUSC./SKEL:		
Joint pain, swelling, redness, or stiffness?		
Muscle pain, fatigue, or weakness?		
History of bone fractures or dislocations?		

PMH & FHx (cont.)	NO	YES	RELATIONSHIP
SKIN:			
Skin cancer			
Psoriasis			
Eczema			
Other			
Other			
NEURO:			
Seizures			
Strokes			
Multiple Sclerosis			
Other			
Other			
PSYCH:			
General Anxiety			
Panic attacks			
Depression			
Suicide attempts			
Schizophrenia			
Bipolar Disorder			
Anorexia			
Bulimia			
Other			

ROS(cont.)	NO	YES
SKIN:		
Do you have any skin condition that you would like to discuss?		
Any moles greater than ½ cm size?		
Any change in mole size, color, or texture?		
NEURO:		
Seizures?		
Dizziness?		
Passing out spells?		
Any numbness, tingling, or weakness in arms or legs?		
Episodes of confusion or trouble speaking?		
PSYCH:		
Are you a nervous person?		
Do you have sudden onset of a sense of doom or loss of control?		
Trouble sleeping?		
Frequent crying spells?		
Loss of interest in social activities?		
Thoughts of harming yourself ?		
Do you make impulse decisions that you regret later?		
Do you have lapses of judgement?		
Do you see or hear things that others don't see or hear?		
Do you feel very uncomfortable around groups of people?		

PSH: Past Surgical History

(List all prior surgeries performed on YOU.)

____

____

____

____

____

____

____

____

____

____

SH: Social History

(Please, answer the following.)

Occupation: ______________________________

List any potential work related hazards: ______________________________

Any chemicals that you are regularly exposed to? ______________________________

Do you use (or have you used)
any form of tobacco products? **NO /YES**
How Much? __________
Have you quit? **Y / N**
If yes, then when? __________

Do you (or did you in the past) drink alcohol? **NO YES**
How much? ______________________________
How often? ______________________________

Do you use (or have you used) any Drugs? **NO YES**
Type(s) of drug: ______________________________

ALLIERGIES TO MEDICATIONS :

______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

CURRENT MEDICATIONS *(Name, Strength of the drug[ie Mg], number of pills per dose, How often do you dose per day)*:

Example:
Tylenol, 325 Mg, 2 pills, every 6 hrs ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

HEALTH PROMOTION and MAINTAINANCE / DISEASE and INJURY PREVENTION:

For Women only:

Do You do ***self breast exams***? **N______** **Y______**

Date of last ***PAP*** smear? (Mo/Yr)? ______/______

If over 40 yr, when was your last ***mammogram***? ______/______

Date of your last ***cholesterol*** blood test? ______/______

For Men only?

Do you do self ***scrotum and testicle exams***?**N______Y______**

If over age 40, date of your last ***PSA*** blood test (Mo/Yr)? ______/______

If over age 40, date of your last ***digital rectal prostate*** exam? ______/______

Date of your last ***cholesterol*** blood test? ______/______

For all patients:

If you are over age 50, have you received ***stool sampling cards*** to check your stool for blood in the past year? **N______Y______N/A____**

If you are over age 50, have you had a screening ***colonoscopy*** (lighted tube up into colon) in the past 5 years? **N______Y______N/A____**

Have you had a ***tetanus*** immunization in the past 10 yrs? **N______Y______**

If you have any chronic respiratory or cardiac illness, or history of spleen removed, have you had a ***pneumonia shot***?**N______Y______N/A____**

Have you had a ***flu immunization*** within the past year? **N______Y______**

Has anyone ever talked to you about a ***Living Will*** **N__Y__**. Do you have a ***Living Will****?* **N______Y______**

Have you talked to your family about your ***end of life wishes*** and whether to use or not use life support? **N______Y______**