Patient Health History

3 6 - 9 3 4 3 6 8

DIRECTION OF FEED

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.
- Fill in date on the line when MM/YR is present.

Correct Mark ● Incorrect Marks ✓ ✗

Name: _____

Date of Appt: _____

1. Race *(Mark Only One)*

American Indian or Alaskan Native	○	Native Hawaiian or Other Pacific Islander	○
Asian	○	Some Other Race	○
Black or African American	○	White	○
Decline to State	○		

2. Ethnicity *(Mark Only One)*

Decline to State	○	Not Hispanic or Latino	○
Hispanic or Latino	○		

3. Preferred Language *(Mark Only One)*

English	○	Spanish	○

4. Preferred method of receiving office reminders *(Mark Only One)*

Opt Out	○	Home Fax	○
Home Phone	○	Work Fax	○
Work Phone	○	Mail	○
Mobile Phone	○	Patient Portal	○
Other Phone	○		

5. Food Allergies or Intolerances

	Yes		Yes
Eggs	○	Yeast – Baker's	○

6. Cancers

	Date Diagnosed	Yes
Bladder	MM / YR	○
Bone	MM / YR	○
Brain	MM / YR	○
Breast	MM / YR	○
Cervical	MM / YR	○
Colon	MM / YR	○
Esophagus	MM / YR	○
Ewing's Sarcoma	MM / YR	○
Hodgkin's Disease	MM / YR	○
Kaposi Sarcoma	MM / YR	○
Kidney	MM / YR	○
Larynx	MM / YR	○
Leukemia	MM / YR	○
Liver	MM / YR	○
Lung	MM / YR	○
Lymphoma	MM / YR	○
Multiple Myeloma	MM / YR	○
Ovarian	MM / YR	○
Pancreas	MM / YR	○
Pheochromocytoma	MM / YR	○
Polycythemia Vera	MM / YR	○
Prostate	MM / YR	○
Rectum	MM / YR	○
Skin – Basal Cell	MM / YR	○

6. Cancers *(continued)*

	Date Diagnosed	Yes
Skin – Malignant Melanoma	MM / YR	○
Skin – Squamous Cell	MM / YR	○
Skin – Unknown Type	MM / YR	○
Stomach	MM / YR	○
Testicular	MM / YR	○
Throat	MM / YR	○
Thyroid	MM / YR	○
Uterine	MM / YR	○

7. Past Health History

	Date Diagnosed	Yes
High Blood Pressure (Hypertension)		○
Pregnant – Pregnancy Has Been Confirmed		○
Encephalopathy		○
Neuralgia	MM / YR	○
Neuritis	MM / YR	○
Paralysis	MM / YR	○
Progressive Neurologic Disorder		○
Radiculitis	MM / YR	○
Intravenous Drug Abuse	MM / YR	○
Autoimmune Disorder		○
HIV Positive (Asymptomatic)		○

8. Past Surgeries

	Procedure Date	Yes
Colectomy – Total		○
Colonoscopy	MM / YR	○
Hysterectomy		○
Mastectomy – Details Unspecified		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Modified Radical		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Radical		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Simple		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○

EXAMPLE TO FILL IN DATES

If you have had paralysis in December of 1990, fill in the oval and write the date as shown below.

Paralysis 12/90 ●

934368

934368

9. Mark any back injuries you have had:

	Injury Date	Yes
Thoracic injury of the back	MM / YR	○
Lumbar injury of the back	MM / YR	○
Ruptured disc – L1-2	MM / YR	○
Ruptured disc – L2-3	MM / YR	○
Ruptured disc – L3-4	MM / YR	○
Ruptured disc – L4-5	MM / YR	○
Ruptured disc – L5-S1	MM / YR	○
Ruptured disc – S1-2	MM / YR	○
Ruptured disc – Specific location unknown	MM / YR	○
Wound (gun shot) to back	MM / YR	○
Wound (stab wound) to back	MM / YR	○
Vertebral fracture – Lumbar	MM / YR	○
Vertebral fracture – Thoracic	MM / YR	○
Vertebral fracture – Location unspecified	MM / YR	○

10. Immunizations Immunization Date

Diptheria – Tetanus – Pertussis (DTP)

MARK EITHER:		Yes
Completed series	MM / YR	○
OR		
#4 of series	MM / YR	○
#5 of series	MM / YR	○

Haemophilus Influenza Type B Conjugate Vaccine (HIB)

MARK EITHER:		Yes
Had series in past	MM / YR	○
OR		
#2 of series	MM / YR	○
#3 of series	MM / YR	○
Booster	MM / YR	○

Hepatitis A (HAV)

		Yes
#2 of series	MM / YR	○
Booster	MM / YR	○

Hepatitis B Vaccine (HBV)

MARK EITHER:		Yes
Had the series	MM / YR	○
OR		
#3 of series	MM / YR	○
#4 of series	MM / YR	○
Repeat series was administered	MM / YR	○
Booster	MM / YR	○

Influenza Vaccine

		Yes
Never received this vaccine		○
Has received this vaccine	MM / YR	○
Declined vaccine		○

Measles – Mumps – Rubella (MMR)

MARK EITHER:		Yes
Completed the series	MM / YR	○
OR		
First or only MMR vaccination	MM / YR	○
Second MMR vaccination	MM / YR	○

10. Immunizations *(continued)* Immunization Date

Pneumococcal Conjugate Vaccine (PCV)

(Pneumonia vaccine given as a child)		Yes
Booster	MM / YR	○

Pneumococcal Polysaccharide Vaccine (PPV)

(Pneumonia vaccine given as an adult)		Yes
Primary PPV immunization	MM / YR	○
Revaccination	MM / YR	○

Polio – Inactivated Polio Virus (IPV)

MARK EITHER:		Yes
Completed the series	MM / YR	○
OR		
#3 of series	MM / YR	○
#4 of series	MM / YR	○

Rotavirus Vaccine

MARK EITHER:		Yes
Has received 2 or more doses	MM / YR	○
OR		
#2 of series	MM / YR	○
#3 of series	MM / YR	○

Varicella (VZV)

MARK EITHER:		Yes
Has received 1 or more doses	MM / YR	○
OR		
#1 or only immunization	MM / YR	○
#2	MM / YR	○

11. Most Recent Diagnostic/Screening Tests

	Test Date	Yes
Colonoscopy	MM / YR	○
Fecal Occult Blood Testing (FOBT)	MM / YR	○
Sigmoidoscopy – Flexible	MM / YR	○
Pap Smear	MM / YR	○
Mammography	MM / YR	○

12. Current Smoking Status

(Mark one of the following)	Yes
Never smoked	○
Former smoker	○
Current every day smoker	○
Current some day smoker	○

13. Use of tobacco products in the past that are no longer used.

(Mark if applicable) ○

Thank you for completing this questionnaire!