

Patient Health History

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



DIRECTION OF FEED

1. Race (Mark Only One)

- | | | | |
|-----------------------------------|-----------------------|---|-----------------------|
| American Indian or Alaskan Native | <input type="radio"/> | Native Hawaiian or Other Pacific Islander | <input type="radio"/> |
| Asian | <input type="radio"/> | Some Other Race | <input type="radio"/> |
| Black or African American | <input type="radio"/> | White | <input type="radio"/> |
| Decline to State | <input type="radio"/> | | |

2. Ethnicity (Mark Only One)

- | | | | |
|--------------------|-----------------------|------------------------|-----------------------|
| Decline to State | <input type="radio"/> | Not Hispanic or Latino | <input type="radio"/> |
| Hispanic or Latino | <input type="radio"/> | | |

3. Preferred Language (Mark Only One)

- | | | | |
|---------|-----------------------|---------|-----------------------|
| English | <input type="radio"/> | Spanish | <input type="radio"/> |
|---------|-----------------------|---------|-----------------------|

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

- | | | | |
|--------------|-----------------------|----------------|-----------------------|
| Opt Out | <input type="radio"/> | Home Fax | <input type="radio"/> |
| Home Phone | <input type="radio"/> | Work Fax | <input type="radio"/> |
| Work Phone | <input type="radio"/> | Mail | <input type="radio"/> |
| Mobile Phone | <input type="radio"/> | Patient Portal | <input type="radio"/> |
| Other Phone | <input type="radio"/> | | |

5. Food Allergies or Intolerances

- | | | | |
|------|-----------------------|-----------------|-----------------------|
| | <u>Yes</u> | | <u>Yes</u> |
| Eggs | <input type="radio"/> | Yeast – Baker's | <input type="radio"/> |

6. Cancers

- | | Date Diagnosed | Yes |
|-------------------|----------------|-----------------------|
| Bladder | | <input type="radio"/> |
| Bone | | <input type="radio"/> |
| Brain | | <input type="radio"/> |
| Breast | | <input type="radio"/> |
| Cervical | | <input type="radio"/> |
| Colon | | <input type="radio"/> |
| Esophagus | | <input type="radio"/> |
| Ewing's Sarcoma | | <input type="radio"/> |
| Hodgkin's Disease | | <input type="radio"/> |
| Kaposi Sarcoma | | <input type="radio"/> |
| Kidney | | <input type="radio"/> |
| Larynx | | <input type="radio"/> |
| Leukemia | | <input type="radio"/> |
| Liver | | <input type="radio"/> |
| Lung | | <input type="radio"/> |
| Lymphoma | | <input type="radio"/> |
| Multiple Myeloma | | <input type="radio"/> |
| Ovarian | | <input type="radio"/> |
| Pancreas | | <input type="radio"/> |
| Pheochromocytoma | | <input type="radio"/> |
| Polycythemia Vera | | <input type="radio"/> |
| Prostate | | <input type="radio"/> |
| Rectum | | <input type="radio"/> |
| Skin – Basal Cell | | <input type="radio"/> |

Name: _____

Date of Appt: _____

6. Cancers (continued)

- | | Date Diagnosed | Yes |
|---------------------------|----------------|-----------------------|
| Skin – Malignant Melanoma | | <input type="radio"/> |
| Skin – Squamous Cell | | <input type="radio"/> |
| Skin – Unknown Type | | <input type="radio"/> |
| Stomach | | <input type="radio"/> |
| Testicular | | <input type="radio"/> |
| Throat | | <input type="radio"/> |
| Thyroid | | <input type="radio"/> |
| Uterine | | <input type="radio"/> |

7. Past Health History

- | | Date Diagnosed | Yes |
|---|----------------|-----------------------|
| High Blood Pressure (Hypertension) | | <input type="radio"/> |
| Pregnant – Pregnancy Has Been Confirmed | | <input type="radio"/> |
| Encephalopathy | | <input type="radio"/> |
| Neuralgia | | <input type="radio"/> |
| Neuritis | | <input type="radio"/> |
| Paralysis | | <input type="radio"/> |
| Progressive Neurologic Disorder | | <input type="radio"/> |
| Radiculitis | | <input type="radio"/> |
| Intravenous Drug Abuse | | <input type="radio"/> |
| Autoimmune Disorder | | <input type="radio"/> |
| HIV Positive (Asymptomatic) | | <input type="radio"/> |

8. Past Surgeries

- | | Procedure Date | Yes |
|----------------------------------|----------------|-----------------------|
| Colectomy – Total | | <input type="radio"/> |
| Colonoscopy | | <input type="radio"/> |
| Hysterectomy | | <input type="radio"/> |
| Mastectomy – Details Unspecified | | <u>Yes</u> |
| Left Separate | | <input type="radio"/> |
| Right Separate | | <input type="radio"/> |
| Both at Same Time | | <input type="radio"/> |
| Mastectomy – Modified Radical | | <u>Yes</u> |
| Left Separate | | <input type="radio"/> |
| Right Separate | | <input type="radio"/> |
| Both at Same Time | | <input type="radio"/> |
| Mastectomy – Radical | | <u>Yes</u> |
| Left Separate | | <input type="radio"/> |
| Right Separate | | <input type="radio"/> |
| Both at Same Time | | <input type="radio"/> |
| Mastectomy – Simple | | <u>Yes</u> |
| Left Separate | | <input type="radio"/> |
| Right Separate | | <input type="radio"/> |
| Both at Same Time | | <input type="radio"/> |

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

9. Mark any back injuries you have had:

Injury Date **Yes**

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

10. Immunizations Immunization Date

Diphtheria – 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
- OR
- #2 of series
- #3 of series
- Booster

Hepatitis A (HAV) **Yes**

- #2 of series MM / YR
- Booster MM / YR

Hepatitis B Vaccine (HBV)

MARK EITHER: **Yes**

- Had the series
- OR
- #3 of series
- #4 of series
- Repeat series was administered
- Booster

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
- OR
- First or only MMR vaccination
- Second MMR vaccination

10. Immunizations (continued) Immunization Date

Pneumococcal Conjugate Vaccine (PCV) **Yes**
 (Pneumonia vaccine given as a child)

- Booster MM / YR

Pneumococcal Polysaccharide Vaccine (PPV) **Yes**
 (Pneumonia vaccine given as an adult)

- Primary PPV immunization
- Revaccination

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 **Yes**

MARK EITHER:

- Has received 2 or more doses
- OR
- #2 of series
- #3 of series

Varicella (VZV) (Chickenpox vaccine) **Yes**

MARK EITHER:

- 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
- Fecal Occult Blood Testing (FOBT)
- Sigmoidoscopy – Flexible
- Pap Smear
- Mammography

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)