EXCELSIOR FAMILY MEDICINE

PATIENT HEALTH HISTORY

Name _____ Today's Date _____

☐ Male ☐ Female Birthdate _____ Date of last physical examination _____

Marital Status _____ Occupation _____

What is the reason for your visit today? _____

HEALTH MAINTENANCE List the most recent date for each of the following:

WOMEN ONLY	BOTH MEN AND WOMEN	MEN ONLY
_____Menstrual Period	_____Cholesterol testing	_____Prostate Exam
_____Mammogram	_____Colonoscopy	_____PSA (prostate Blood test)
_____Pap Smear	_____Tetanus booster	
	_____Pneumonia Vaccine	
	_____Bone Density (DEXA)	

CONDITIONS Check ☒ conditions you currently have or have had in the past

☐ ADHD	☐ Chemical dependency	☐ Hiatal Hernia	☐ Prostate Problems
☐ AIDS	☐ COPD/Emphysema	☐ High Blood Pressure	☐ Psoriasis
☐ Alcoholism	☐ Crohn's Disease	☐ High Cholesterol	☐ Psychiatric Care
☐ Allergies, Seasonal	☐ Dementia	☐ HIV positive	☐ Pulmonary Embolism
☐ Anemia	☐ Depression	☐ Irritable Bowel Syndrome	☐ Rheumatic Fever
☐ Anorexia	☐ Diabetes: 1 or 2	☐ Kidney Disease	☐ Rheumatoid Arthritis
☐ Anxiety	☐ Diverticulitis	☐ Kidney Stones	☐ Rhinitis
☐ Arrhythmia	☐ DVT (Blood Clot)	☐ Liver Disease	☐ Sexually Transmitted Infections
☐ Arthritis	☐ Epilepsy	☐ Lupus	
☐ Asthma	☐ GERD (reflux)	☐ Macular Degenerations	☐ Sleep Apnea
☐ Bipolar	☐ Glaucoma	☐ Multiple Sclerosis	☐ Stroke
☐ Bladder Problems/Incontinence	☐ Goiter	☐ Neuropathy	☐ Suicide Attempt
☐ Bleeding Disorder	☐ Gout	☐ Osteopenia/Osteoporosis	☐ Thyroid Disorder
☐ Breast Lump	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Bronchitis	☐ Heart Attack (MI)	☐ Parkinson's Disease	☐ Ulcerative Colitis
☐ Bulimia	☐ Heart Disease	☐ Peptic Ulcer	☐ Ulcers
☐ CAD/Heart disease	☐ Hepatitis	☐ Peripheral Vascular Disease	☐ Vaginal Infections
☐ Cancer: _____	☐ Herpes	☐ Pneumonia	

☐ OTHER medical problems not listed above: _____

ALLERGIES Check ☒ appropriate box below. If yes, please list all known allergies to medications or substances

☐ No known allergies ☐ YES, I have the following allergies:

What was the reaction?

MEDICATIONS List all medications you are currently taking, including the dose and frequency

Medication	Dose	Frequency

Health History Continued: Patient Name _____

SURGICAL HISTORY		
Year	Hospital/City, State	Type of surgery/Complications if any

OTHER HOSPITILZATIONS, SERIOUS ILLNESSES, INJURIES		
Year	Hospital/City, State	Reason for hospitalizations, nature of illness or injury

PREGNANCY HISTORY

Pregnancies: _____ # Living Children: _____ # Deliveries: C-Sections: _____ Vaginal: ____

Birth Year	M or F	Complications if any

FAMILY HISTORY Fill in information about your family below				Check ☒ if blood relative has had any of the following.	
Relation	Age If Living	Age At death	Medical condition / Cause of death	Disease	Relationship to you
Father				☐ Arthritis	
Mother				☐ Asthma	
Brothers				☐ Cancer	
				☐ Diabetes	
				☐ Gout	
				☐ Heart Disease	
Sisters				☐ High Blood Pressure	
				☐ Kidney Disease	
				☐ Stroke	
				☐ Other	

HEALTH HABITS	Check ☒ appropriate boxes below and describe
Caffeine	☐ Current ☐ Past ☐ Never Amount per day/week:
Tobacco	☐ Current ☐ Past ☐ Never Type: Amount/day: Number of Year:
Alcohol	☐ Current ☐ Past ☐ Never Drinks/week:
Drugs	☐ Current ☐ Past ☐ Never Type:
Diet	Describe:
Exercise	Describe:
Seat Belts	☐ Always ☐ Never ☐ Sometimes

Health History Continued: Patient Name _____

SOCIAL/CULTURAL HISTORY
Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate/Professional
Are there any limitations to understanding or following instructions; either written or verbal? ☐ Yes ☐ No
Current Living Situation Check ☒ all the apply ☐ Single Family Household ☐ Multi-generation Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other:
Are you sexually active? ☐ Yes ☐ No
Sexual Orientation: ☐ Straight ☐ Lesbian, Gay, Queer (Homosexual) ☐ Bisexual ☐ Do Not Want to Answer ☐ Transitioning to Female ☐ Transitioning to Male ☐ Transexual
Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐ Yes ☐ No
Are there any cultural or religious concerns you have related to our delivery of care? ☐ Yes ☐ No
Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐ No
How often do you get the social and emotional support you need? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never
Comments:

LIST OFTHER MEDICAL PROVIDERS YOU SEE ON A REGULAR BASIS		
Name of Provider	Specialty	Approximate Date of Last Visit

Patient Signature: _____ Date: _____