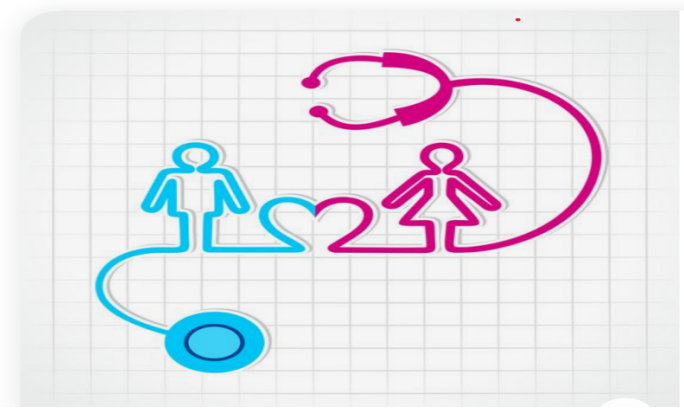

Healthy Living Medical Clinic Health Form

Date: _____

Last Name: _____ First Name: _____ MI: ___

Date of Birth: _____ DL#: _____

Address: _____

City, State, Zip Code:

_____

Cell #: _____ Home #: _____ Work #: _____

Email Address: _____

Which is the best way to reach you and or remind you of future appointments?

☐ Cell phone ☐ Home phone ☐ Work phone ☐ Email address

Preferred Pharmacy Name and #:

_____

Emergency Contact and #: _____

How did you hear about us? _____

Other Physicians Currently Involved in Your Care:

Primary Care Provider Name & #:

_____

Allergies to Medications

(Prescriptions, Supplements and OTC)

☐ **None**

Medication	Reaction

Preventive Health History

Write the **date AND results** of the following preventative health screening exams

Screening Exam	Date and Results
Rectal Exam	
Prostate Exam	
PSA blood test	
Cholesterol test	
Gyne Exam/PAP	
Mammogram	
Breast Exam	
Bone Density	
Colonoscopy	

Your Current or Past Medical History

Check if you have had any of the following:

- ☐ Abn. Heart Rhythm
- ☐ Allergies/Seasonal
- ☐ Anemia
- ☐ Anxiety / Stress
- ☐ Asthma
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Back Pain /Neck Pain
- ☐ Colitis or Crohn's
- ☐ Fractures
- ☐ Cancers (any type)
- ☐ Chronic Pain
- ☐ Chronic Kidney Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema / COPD
- ☐ Gallbladder Disease
- ☐ Headaches / Migraines
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heartburn / GERD
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hepatitis, Type ____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ IBS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Obesity
- ☐ Osteopenia/ Osteoporosis
- ☐ Vascular Problems
- ☐ Palpitations
- ☐ Seizures / Epilepsy
- ☐ Sleep Apnea
- ☐ Stomach / Digestive Problems
- ☐ Stroke
- ☐ Thyroid Disease

☐ _____

☐ Other

Family History

	Which Relative? (Mother, Father, Brothers, Sisters, Maternal or Paternal Grandparents, Aunts, Uncles)
☐ Alcoholism/Drug Abuse	
☐ Anxiety	
☐ Arthritis	
☐ Bleeding/ Blood Disorder	
☐ Breast Cancer	
☐ Colitis/Crohn's Disease	
☐ Colon Cancer	
☐ Colon Polyps	
☐ Depression	
☐ Diabetes	
☐ Heart Attack/ Heart Dsease	
☐ Heart Failure	
☐ High Blood Press	
☐ High Cholesterol	
☐ Kidney Stones	
☐ Kidney Disease/Failure/Dialysis	
☐ Liver Disease	
☐ Lung Cancer	
☐ Migraine headache	
☐ Prostate Cancer	
☐ Skin Cancers (Melanoma)	
☐ Stomach or Digestive Problems	
☐ Stroke	
☐ Suicide	
☐ Thyroid disease	
☐ Other Cancers Not Listed	
☐ Other Conditions Not Listed	

Past Surgical History

☐ **None**

Date	Surgery

Medications

Please list ALL Prescriptions, Supplements and OTC medication you are currently taking

☐ **None**

Medication/Vitamins/Supplements	Dose	Frequency

Social History

Marital Status: (Circle) Single Married Divorced Widowed

Smoking History: (Check off or fill in what applies)

_____ Never smoked _____ Currently smoke Year started _____

_____ Smoked in past but have quit Year quit _____

_____ Cigarettes _____ Cigars _____ Pipe _____ Marijuana

Amount smoked per day: _____ packs

Alcohol Use:

Drink Alcohol?: Yes No

How many drinks per day? _____ How many drinks per week? _____

What type of alcohol: (Circle) Beer Wine Liquor _____

Illicit Drug Use:

Do you now or have you in the past used any illicit drugs? Yes No

If yes, what substance: Cocaine Amphetamines Opioids Crystal Meth Heroin LSD

Other _____

How often? _____

Health Habits:

Sleep: Sleep _____ # of hours per night

Insomnia Sleep Apnea Snore

Difficulty falling asleep Waking up frequently during the night

Exercise:

Your level of exercise is: ____ Sedentary – Almost never ____ Occasional 2-3 times/ week
____ More than 4 times/ week ____ Daily

Types of exercise activity and frequency

Any Additional Medical Information

(not covered in prior sections)

System Review – Check the appropriate box for each question.			
Constitutional / ID / Oncology	**Yes**	**No**	**Not Sure**
Have you had unexplained weight loss?			
Do you have fever and chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever unexplained weight loss or weight gain?			
Have you ever had a sexually transmitted disease?			
Respiratory			
Do you have a persistent cough?			
Do you have recurrent sinus infections?			
Do you have excessive daytime sleepiness?			

Cardiovascular	**Yes**	**No**	**Not Sure**

Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Vascular disease or artery blockages/aneurysms?			
Have you ever been diagnosed with a blood clot?			
Gastrointestinal			
Do you have problems swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or swelling?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine			
Do you urinate frequently or in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Do you have elevated bood sugar? Diabetes?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
Neurological			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Urologic / Renal			
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems?			

Release of Medical Information

Do you authorize anyone other than yourself to receive your health information? Yes No

If so, whom:_____
Relationship:_____

If so, who_____
Relationship_____

Patient Signature: ____

Date: __________________