WAVERLY HEALTH CENTER

PATIENT HEALTH HISTORY FORM

Name: _____ Date of Birth: _____

Patient Signature/Date: _____

Medical Provider Signature/Date: _____

CURRENT MEDICATIONS

☐ I take no medications, vitamins, minerals, or herbs.

Medication/Vitamins/Minerals/Herbs	Dose/Strength	#/Amount You Take	How Often it is Taken

Pharmacy Used:

Please list additional medications on the back page. Check here if you have listed additional medications: ☐

MEDICAL HISTORY (Please check all that **YOU** have now or in the past)

Heart Conditions
Name of Cardiologist (if applicable):

	Myocardial Infarction (heart attack)		Atrial Fibrillation
	Coronary Artery Disease (bypass or stent)		Intracardiac Device (please circle: pacemaker or defibrillator)
	Hypertension (high blood pressure)		Peripheral Vascular Disease
	Hyperlipidemia (high cholesterol)		Abdominal Aortic Aneurysm (AAA)
	Congestive Heart Failure		Other (specify)

Lung Conditions
Name of Pulmonologist (if applicable):

	Asthma		Obstructive Sleep Apnea
	COPD (emphysema)		Restless Leg Syndrome
	Interstitial Lung Disease (pulmonary fibrosis)		Tuberculosis

Gastrointestinal Conditions Name of Gastroenterologist (if applicable):			
	Gastroesophageal Reflux Disease (heartburn)		Diverticulitis
	Inflammatory Bowel Disease (Crohn's Disease or Ulcerative Colitis)		Pancreatitis
	Irritable Bowel Syndrome		Cholelithiasis (gallstones)
	GI Bleed		Hepatitis B or C
	Date of Last Colonoscopy:		Other (specify)

Kidney Conditions Name of Nephrologist (if applicable):			
	Chronic Kidney Disease		Nephrolithiasis (kidney stone)
	Dialysis (please circle access site: fistula, graft or catheter)		Other (specify)

Blood or Cancer Conditions Name of Hematologist/Oncologist (if applicable):			
	Cancer (specify type)		Coagulopathy (clotting disorder)
	Transplant (specify type)		Deep Venous Thrombosis (blood clot in leg)
	Leukemia		Pulmonary Embolism (blood clot in lungs)
	Lymphoma		Anemia

Endocrinology Conditions Name of Endocrinologist (if applicable):			
	Type I Diabetes Mellitus		Hyperthyroidism (overactive thyroid)
	Type II Diabetes Mellitus		Hypothyroidism (underactive thyroid)
	Other (specify):		Other (specify):

Mental Health Conditions Name of Psychiatrist (if applicable):			
	Anxiety		Attention Deficit-Hyperactivity Disorder
	Depression		Insomnia
	Bipolar Disorder		Other (specify)

Patient Name: _____ **Patient DOB:** _____

Neurologic Conditions Name of Neurologist (if applicable):			
	Transient Ischemic Attack (TIA)		Seizures/Epilepsy
	Cerebrovascular Accident (stroke)		Migraine Headaches
	Other (specify)		Other (specify)

Other Conditions Other Specialty Providers:			
	Rheumatoid Arthritis		Benign Prostatic Hypertrophy Enlarged Prostate
	Gout (arthritis)		Erectile Dysfunction
	Osteoporosis		Allergic Rhinitis (seasonal allergies)
	Fibromyalgia		AIDS/HIV
	Cataracts/Glaucoma		Fractures
	Sexually Transmitted Infections		Other:

MEDICATION ALLERGIES ☐ I have no allergies to medications.

Do you have an allergy to latex? Yes No

Please list any allergies to medications. Please specify type of allergy or reaction:

GYNECOLOGICAL HISTORY (for females only)

Age Periods Began:	First Day of Last Period:
Length of Periods (# of Days of Bleeding):	
# of Days Between Periods:	
Any Recent Changes in Periods: Yes No	
Specify Changes:	
Present Method of Preventing Pregnancy:	
Have you ever had an abnormal pap smear?	If yes, when and how was it treated?

Patient Name: _____ **Patient DOB:** _____

Date of last mammogram and result:
Have you ever had an abnormal mammogram?
Date of last pap smear and result:

OBSTETRIC HISTORY (females only)

Are you, or could you be, pregnant? Yes No						
# of Pregnancies:			# of Abortions:		# of Miscarriages:	
# of Premature Births: (<37 wks)			# of Live Births:		# of Living Children:	
No.	Birth Date	Weight at Birth	Baby's Sex	Weeks Pregnant	Type of Delivery	Complications
1						
2						
3						
4						
5						

Describe your daily dairy product intake and/or calcium supplements:

_____

_____

SURGERIES AND HOSPITALIZATIONS

☐ I have had no surgeries or hospitalizations.

Reason/Procedure	Year	Hospital/Provider
Please list additional surgeries/hospitalizations on the back page. Check here if you have listed additional: ☐		

Patient Name: _____ **Patient DOB:** _____

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FAMILY HISTORY (Please answer for your immediate family members only – children, siblings and parents; not for yourself)

Father: ☐ Living ☐ Deceased Year of birth:_____ If applicable, please describe cause of death and age:	Mother: ☐ Living ☐ Deceased Year of birth:_____ If applicable, please describe cause of death and age:
Siblings:	# Living _____ # Deceased _____ Year(s) of birth:_____ If applicable, please describe cause of death and age:
Children:	# Living _____ # Deceased _____ Year(s) of birth:_____ If applicable, please describe cause of death and age:

Illness	x	Relative/Age of Onset	Illness	x	Relative/Age of Onset
Alcoholism			Genetic Disease		
Anemia			Heart Attack		
Anxiety			High Blood Pressure		
Asthma			High Cholesterol		
Birth Defect			Kidney Disease		
Blood Clots			Migraine Headaches		
Cancer (specify type)			Osteoporosis		
Dementia			Rheumatoid Arthritis		
Depression			Stroke		
Diabetes			Thyroid Disorder		
Epilepsy (Seizures)			Other (specify)		

SOCIAL HISTORY

Current Smoker	Y N	Frequency: # of Yrs. Smoked:
Previous Smoker	Y N	Date Quit: Past Frequency: # of Yrs. Smoked:
Oral Tobacco	Y N	Frequency: Yrs. Used:
Alcohol	Y N	Frequency: History of Alcoholism: Y N
Drug use	Y N	Drugs used:
Exercise	Y N	Frequency:

Patient Name: _____ **Patient DOB:** _____

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Caffeine	Y N	Amount per day or week:
Marital Status:		Occupation:
Have you ever been abused, threatened or hurt by anyone?		
Are you currently sexually active? _____ Yes _____ No If yes, are you sexually active with men, women, or both? _____		
Do you have any beliefs, religious or cultural practices that your healthcare team should be aware of in order to provide the best care for you? ___ Yes ___ No		

MEDICAL SYMPTOMS (Please circle symptoms you have experienced within the past 6 months)

Abdominal Pain	Numbness
Anxiety	Pain with Urination
Blood in Stool or Urine	Easy Bruising
Breast Lump	Enlarged Lymph Nodes
Breast Pain	Fever
Change in Bowels (constipation or diarrhea)	Heart Palpitations
Chest Pain	Frequent Crying
Chills	Heavy or Irregular Periods
Chronic Fatigue	Indigestion
Cough	Intolerance to Heat or Cold
Dental Problems	Painful Intercourse
Depression	Poor Circulation
Difficulty Breathing	Rash/Skin Problems
Difficulty Urinating	Sinus Problems
Dizziness	Sore Throat
Easy Bleeding	Spitting up Blood
Joint Pain	Swelling(specify location)
Loss of Appetite	Trouble Swallowing
Mouth Sores	Trouble Sleeping
Muscle Weakness	Vision Changes
Nasal Congestion	Weight Gain or Weight Loss
Nausea or Vomiting	Other:
Night Sweats	Other:
Nipple Discharge	Other:

COMMENTS:

_____

_____

_____

Patient Name: _____ **Patient DOB:** _____