marinhealth Medical Network

HEALTH HISTORY FORM

Name: ______________________________ **Date:** ______________

Date of Birth: ______________ **Age:** ______

Who are your doctors?

Special Primary Care	
Specialists	

What medical problems would you like to discuss today? ______________________________

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Please circle the diagnoses that apply, and add any additional problems not listed below.

High Blood Pressure	High Cholesterol	Diabetes	Neuropathy
Carotid Artery Disease (Stenosis)	Irregular Heartbeat	Heart Attack	Heart Murmur
Cancer	Arthritis	Stroke	Kidney Disease
Blood Clots	Abnormal Bleeding	Stomach Ulcers	Foot Ulcers

Please list additional medical problems and hospitalizations:

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________
5) ______________________________
6) ______________________________
7) ______________________________

Surgical History – List all the surgeries with the month/ year and where they were performed:

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________

Have you ever had problems with anesthesia? Yes No

Name: ____ *Date of Birth:* ____________

Please provide your most recent medication list. Include herbal supplements and over the counter medications:

Medication	Dose	Frequency

Are you allergic to contrast (x-ray dye) or shellfish? Yes No

Do you have any known drug allergies? Yes No

If so, please list below:

Medication Allergy	Reaction

PERSONAL BACKGROUND

Have you ever been a smoker? Yes No

If yes, at what age did you start? ________________________________

At what age did you stop (if you have)? ________________________________

How many packs per day did/do you smoke? ________________________________

Do you drink alcohol regularly? Yes No

If yes, how much daily? ________________________________

Do you think you've ever had a problem with drinking? ________________________________

Are you working? Yes No

What is your occupation? ________________________________

Do you exercise regularly? Yes No

What do you do for exercise? ________________________________

How far can you walk? ________________________________

Name: ______________________________________ *Date of Birth:* ____________

FAMILY HISTORY

	Age	Health Problems	If deceased, Cause	Age at death
Mother:				
Father:				
Brothers/Sisters:				
Children:				

Any family history of heart disease or stroke? Yes No

GENERAL HEALTH REVIEW

Vascular

Have you ever had vascular surgery before?	Yes	No
Do you have pain in your legs when you walk?	Yes	No
Has anyone in your family had an aortic aneurysm?	Yes	No
Have you ever had weakness or numbness in one arm or leg?	Yes	No
Have you ever lost vision in one eye (either temporarily or permanently)?	Yes	No
Do you have varicose veins?	Yes	No
Do you have abdominal pain after you eat?	Yes	No
Are you right or left handed?	Right	Left

Cardiac

Do you ever have pain in your chest when you walk?	Yes	No
Have you ever had a heart attack or heart surgery or angioplasty?	Yes	No
Do you ever wake up in the night short of breath?	Yes	No
Do you have palpitations or racing heart beat?	Yes	No
Do you have swelling of your legs?	Yes	No
Have you ever had a stress test?	Yes	No

Constitutional

Have you had an unexplained change in your weight (either loss or gain) over the last several months?	Yes	No
Do you have unusual fatigue?	Yes	No
Do you ever have chills/sweats?	Yes	No

HEENT

Do you have difficulty swallowing?	Yes	No
Do you have any mouth or eyesores?	Yes	No
Do you have headaches?	Yes	No
Do you have chronic sinus infections?	Yes	No

Name: ______________________ Date of Birth: ____________

Pulmonary

Question	Yes	No
Do you have chronic bronchitis?	Yes	No
Do you have asthma?	Yes	No
If yes, Have you ever been on prednisone?	Yes	No
Have you ever been on a ventilator/been intubated for asthma?	Yes	No
Do you have sleep apnea?	Yes	No
If yes, are you on a machine at night (BIPAP)?	Yes	No
Do you have emphysema?	Yes	No

Gastrointestinal

Question	Yes	No
Do you have blood in your stools?	Yes	No
Do you ever have black or tarry stools?	Yes	No
Do you have reflux or heartburn?	Yes	No
Have you had a recent change in your bowel movements? (worsening constipation or diarrhea)	Yes	No
Do you have difficulty swallowing?	Yes	No
Do you ever have jaundice, coca cola colored urine, or light (clay colored) stools?	Yes	No
Have you ever had pancreatitis?	Yes	No
Do you have hepatitis, or any problems with your liver?	Yes	No
Have you ever had gallstones?	Yes	No

Urologic/ Gynecologic

Question	Yes	No
Do you have burning when you urinate?	Yes	No
Have you ever had kidney stones?	Yes	No
Do you have impotence?	Yes	No
Do you have recurrent urinary tract infections?	Yes	No

Hematologic

Question	Yes	No
Have you ever had a blood transfusion?	Yes	No
Do you have a tendency to bleed an unusual amount during operations or with childbirth?	Yes	No
Have you ever had a problem with blood clots?	Yes	No

Mental Health

Question	Yes	No
Do you have problems with depression, anxiety, panic attacks, or mania?	Yes	No
Are you currently undergoing treatment with a psychiatrist or counselor?	Yes	No