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HEALTH HISTORY FORM

Date _____

Patient ID _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. If you cannot remember specific details, please provide your best guess. Thank you.

Name _____ SSN _____

Street Address _____

City _____ State _____ ZIP _____

Date of birth _____ Sex _____ Phone (1) _____

Email _____ Phone (2) _____

Name of Study Partner/Caregiver _____ Phone _____

Email _____

Select all that apply to the patient:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Employed FT
- ☐ Employed PT
- ☐ Retired
- ☐ Unemployed

Employer/School _____ Phone _____

Occupation/Studying _____

Years of education/highest degree _____

Nearest relative not living with you _____ Phone _____

Spouse/Partner's name _____ Phone _____

Number of children/ages _____

Who lives at home with you? _____ Phone _____

How were you referred to our services? (Please check all that apply.)

_____ Friend: _____

_____ Family member: _____

_____ Physician: _____

_____ Health Talk _____ Website _____ Community agency _____ TV Ad _____ Health Fair

_____ Newspaper AD _____ Other (specify) _____

REVIEW OF SYMPTOMS - Please check any current symptoms you have.

Constitutional
- ☐ Recent fevers/sweats
- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue/weakness

Eyes
- ☐ Change in vision

Ears/Nose/Throat/Mouth
- ☐ Difficulty hearing/ringing in ears
- ☐ Hay fever/allergies/congestion
- ☐ Trouble swallowing

Cardiovascular
- ☐ Chest pains/discomfort
- ☐ Palpitations
- ☐ Short of breath with exertion

Breast
- ☐ Breast lump
- ☐ Nipple discharge

Respiratory
- ☐ Cough/wheeze
- ☐ Coughing up blood
- ☐ Snoring

Gastrointestinal
- ☐ Heartburn/reflux
- ☐ Blood or change in bowel movement
- ☐ Nausea/vomiting/diarrhea
- ☐ Pain in abdomen

Genitourinary
- ☐ Painful/bloody urination
- ☐ Leaking urine
- ☐ Nighttime urination
- ☐ Discharge: penis or vagina
- ☐ Unusual vaginal bleeding
- ☐ Concern with sexual functions

Musculoskeletal
- ☐ Muscle/joint pain
- ☐ Recent back pain

Skin
- ☐ Rash
- ☐ New or change in mole

Neurological
- ☐ Headaches
- ☐ Memory loss
- ☐ Fainting

Psychiatric
- ☐ Anxiety/stress
- ☐ Sleep problem
- ☐ Depression

Blood/Lymphatic
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

Endo
- ☐ Cold/heat intolerance
- ☐ Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ☐ Yes ☐ No

MEDICATIONS - Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (e.g.mg/pill)	Frequency	Date started

Allergies or reactions to medications _____ Date Started: _____

Date of your most recent **IMMUNIZATIONS**

Hepatitis A _____

Hepatitis B _____

Influenza _____

MMR _____

Pneumonia _____

_____Meningitis _____

_____

Tetanus (Td) _____

Varicella (chicken pox) shot or Illness _____

Tetanus and pertussis (Tdap) _____

HEALTH MAINTENANCE SCREENING TESTS

☐ *Lipid* (cholesterol) _____		Date _____	Abnormal?	☐ Yes	☐ No
☐ *Sigmoidoscopy* or ☐ *Colonoscopy*		Date _____	Abnormal?	☐ Yes	☐ No
Women	☐ *Mammogram*	Date _____	Abnormal?	☐ Yes	☐ No
	☐ *Pap Smear*	Date _____	Abnormal?	☐ Yes	☐ No
	☐ *Dexascan (osteporosis)*	Date _____	Abnormal?	☐ Yes	☐ No
Men	☐ *PSA* (prostate)	Date _____	Abnormal?	☐ Yes	☐ No

PERSONAL MEDICAL HISTORY - Please indicate whether you have had any of the following medical problems (with dates).

☐ Alzheimer's disease	Date _____	Type _____
☐ Heart disease	Date _____	Type _____
☐ High blood pressure	Date _____	Type _____
☐ Diabetes	Date _____	Type _____
☐ Asthma/Lung disease	Date _____	Type _____
☐ High cholesterol	Date _____	Type _____
☐ Thyroid problem	Date _____	Type _____
☐ Kidney disease	Date _____	Type _____
☐ Cancer	Date _____	Type _____
☐ Parkinson's disease	Date _____	Type _____
☐ Memory disorders, Other	Date _____	Type _____
☐ Neurological disorders	Date _____	Type _____

SURGICAL HISTORY - Please list all prior operations (with dates).

_____

_____

FAMILY HISTORY - Please indicate the current status of your immediate family members.

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions.

Alzheimer's disease _____	Alcoholism _____
High cholesterol _____	Cancer, specify type _____
High blood pressure _____	Heart disease _____
Stroke _____	Neurological disorders, Other _____
Depression/suicide _____	Psychiatric disorders, Other _____
Bleeding or clotting disorder _____	Genetic disorders _____
Asthma/COPD _____	Diabetes _____
Parkinson's disease _____	Other _____

SOCIAL HISTORY

Tobacco Use

Cigarettes ☐ Never ☐ Quit Date _____ ☐ Current Smoker __ packs/day __ # yrs

Other Tobacco ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No _____ # drinks/week ☐ Beer ☐Wine ☐Liquor

Is your alcohol use a concern for you or others? ☐ Yes ☐ No

Drug Use

Do you use any recreational drugs? ☐ Yes ☐ No Drugs used:_____

Have you ever used needles to inject drugs? ☐ Yes ☐ No

Sexual Activity

Sexually active ☐ Yes ☐ No ☐ Not currently

Current sex partner(s) is/are ☐ Male ☐ Female

Birth control method _____ ☐ None needed

Ever had any sexually transmitted diseases? ☐ Yes ☐ No

Interest in STD screening? ☐ Yes ☐ No

OTHER CONCERNS

Caffeine Intake - ☐ None ☐ Coffee/tea ☐ Energy drinks/soda _____ cups/day

Weight - Are you satisfied with your weight? ☐ Yes ☐ No

Diet - How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Exercise - Do you exercise regularly? ☐ Yes ☐ No

What kind of exercise? _____

How long (minutes)? _____ How often? _____

Safety - Do you use a bike helmet? ☐ Yes ☐ No ☐ NA

Do you use seatbelts consistently? ☐ Yes ☐ No

Is violence at home a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Do you have a gun in your home? ☐ Yes ☐ No

Have you completed a living will or durable power of attorney for health care? ☐ Yes ☐ No

WOMEN'S HEALTH HISTORY

Age at start of periods _____Age at end of periods _____ ☐ Menopause ☐ Surgical

I certify that the information supplied in this document is accurate and complete to the best of my knowledge.

_____ _____

Signature Date

Patient Name: _____ Date: _____

DOB:_____

Please complete the following in regards to:

Task	Help Needed?	Details: Type of help needed
Using the telephone	Y/N	
Managing their medicines (like taking medicines on time)	Y/N	
Preparing meals	Y/N	
Managing money (like keeping track of expenses or paying bills)	Y/N	
Doing housework (such as doing the laundry)	Y/N	
Shopping for personal items like toiletries or medicines	Y/N	
Shopping for groceries	Y/N	
Driving	Y/N	
Feeding self	Y/N	
Getting from bed to chair	Y/N	
Getting to the toilet	Y/N	
Getting dressed	Y/N	
Bathing or showering	Y/N	
Walking across the room (includes using a cane or walker)	Y/N	
Climbing a flight of stairs	Y/N	
Getting to places beyond walking distance (e.g. by bus, taxi, or car)	Y/N	

☐ Form Completed by Patient

☐ Form Completed by Other: Name _____ Relationship _____

Patient Name: _____ Date:_____

DOB:_____

If the patient has not had brain imaging done, we may recommend it as part of their evaluation.

MRI Safety Screening Sheet

The following items may be hazardous or may interfere with the MR examination by producing an artifact.

Please answer **Yes** or **No** to the following:

Yes No Cardiac Pacemaker, or implanted Cardioverter/Defbrillator (ICD)

Yes No Internal electrodes, wires, retained pacemaker leads

Yes No Brain Aneurysm clip(s) or Aneurysm surgery

Yes No Shunt, Spinal, Intraventricular or Intracranial pressure monitor

Yes No Electronic implant or device. Neurostimulator, Spinal Cord stimulator, Bone fusion stimulator

Yes No Magnetically-activated implant or device

***If Yes, Please List**:_____

Yes No Insulin or drug infusion pump, device

Yes No Medication or nicotine patch

Yes No Epidural catheter, Swanz-Ganz catheter, Groshong or Vascular access port

Yes No Intravascular Coil, Filter or Stent

***If Yes, Please List**:_____

Yes No Any type of Prosthesis or Implant (eye, ear, heart valve, penile, artificial limb, etc)

Yes No Hearing aid (remove before entering MRI scan room)

Yes No Cochlear implant, Stapes implant, ear or otologic implant

Yes No Tissue expander (e.g. breast) or wire mesh implants

Yes No Joint replacement (hip, knee, etc)

Yes No Dentures or removable dental work

Yes No Bone/joint pins, screws, nail, wire, plate, etc

Yes No Diaphragm or IUD

Yes No Body piercing jewelry (remove before entering MRI scan room)

Yes No Permanent makeup or tattoo

***If Yes, Please List**:_____

Yes No Do you have seizures, asthma, or allergic respiratory disease?

Yes No Drug or medication allergies? **Please List**:_____

Yes No Have you had an allergic reaction to contrast media or dye used for MRI?

Yes No Are you pregnant, suspect pregnancy or breast feeding?

Yes No Breathing problem, motion disorder or claustrophobia?