ImRTC™

PATIENTS HEALTH HISTORY FORM
NEW PATIENT ADULT ONLY

Your answers on this form will help us to get an accurate history of your medical concerns and conditions. If you are a current patient and you did fill out this form before, than there is a shorter update form you can use. Please fill in all pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. ***Thank you!***

Patient Name: _____ Date of Birth: ____/____/_____ Sex: _____

Address: _____City/State/Zip: _____

Day Time Phone: _____ Alt. Phone: _____ Identification #: _____

Main reason for today's visit: _____

Other concerns: _____

What are your health goals for the next year? _____

Where were you getting your care before? _____

In the past **2 weeks**, have you been bothered by: Little interest or pleasure in doing things? ____ **No** ____ **Yes**
Feeling down, depressed or hopeless? ____ **No** ____ **Yes**

REVIEW OF SYMPTOMS: Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General
____ Unexplained weight loss / gain
____ Unexplained fatigue / weakness
____ Fall asleep during day when sitting
Fever, chills
____ **No problems**

Skin
____ New or change in mole
____ Rash / itching
No problems

Breast
____ Breast lump / pain / nipple discharge
____ **No problems**

Ears/Nose/Throat
Nosebleeds, trouble swallowing
____ Frequent sore throat, hoarseness
Hearing loss / ringing in ears
____ **No problems**

Eyes
Change in vision / eye pain / redness
____ **No problems**

Respiratory
____ Cough / wheeze
Loud snoring / altered breathing during sleep
Short of breath with exertion
No problems

Gastrointestinal
____ Heartburn / reflux / indigestion
____ Blood or change in bowel movement
Constipation
No problems

Genitourinary
____ Leaking urine
Blood in urine
Nighttime urination or increased frequency
Discharge: penis or vagina
____ Concern with sexual function
No problems

Musculoskeletal
Neck pain
____ Back pain
Muscle / joint pain
____ **No problems**

Hematologic/Lymphatic
____ Swollen glands
Easy bruising
____ **No problems**

Neurological
Headache
Memory loss
____ Fainting
Dizziness
Numbness / tingling
Unsteady gait
Frequent falls
____ **No problems**

Allergic/Immune
Hay fever / allergies
____ Frequent infections
No problems

Psychiatric
Anxiety / stress / irritability
____ Sleep problem
Lack of concentration
____ **No problems**

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Cardiovascular

____ Chest pain / discomfort

____ Palpitations (fast or irregular heartbeat)

____ **No problems**

Endocrine

____ Heat or cold sensitivity

____ **No problems**

Women only

____ Pre-menstrual symptoms (bloating cramps, irritability)

____ Problem with menstrual periods

____ Hot flashes / night sweats

____ **No problems**

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information.

Tetanus (Td) ____ With Pertussis (Tdap) ____ Varicella (Chicken Pox) shot *or* illness ____ Pneumovax (pneumonia) ____

Influenza (flu shot) ____ Hepatitis A ____ Hepatitis B ____ MMR ____ Meningitis ____ Zostavax (shingles) ____ HPV ____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

TAKE NO MEDICATION: _____

Medication:	Dose (e.g. mg/pill)	How many times per day?

Allergies or intolerance to medications (include type of reaction): _____

_____**None: _____**

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol)	Date:_____	Abnormal?	NO: ____	YES: ____
Sigmoidoscopy or Colonoscopy (circle one)	Date:_____	Polyp?	NO: ____	YES: ____
Women Only:				
Mammogram	Date:_____	Abnormal?	NO: ____	YES: ____
Pap Smear	Date:_____	Abnormal?	NO: ____	YES: ____
Bone Density Test	Date:_____	Abnormal?	NO: ____	YES: ____

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions?

Condition	*Code*	*Current*	*Past*	*Comments*
Alcohol / Drug abuse				
Allergy (Hay Fever)				
Anemia				
Anxiety				

Condition (Continue)	*Code*	*Current*	*Past*	*Comments*
Arthritis (Rheumatoid)				
Arthritis (Osteoarthritis)				
Asthma				
Bladder / Kidney Problems				
Blood Clot (leg)				
Blood Clot (lung)				
Blood Transfusion				
Breast Lump (benign)				
Cancer Breast				
Cancer Colon				
Cancer Other Type				
Cancer Ovarian				
Cancer Prostate				
Cataracts				
Chicken Pox				
Colon Polyp				
Coronary Artery Disease				
Depression				
Diabetes (adult onset)				
Diabetes (childhood onset)				
Diverticulosis				
Emphysema				
Fractures (broken bones)				Where?
Gallbladder Disease				
Gastroesophageal Reflux (Heartburn/GERD)				
Glaucoma				
Gout				
Gynecological Conditions (Endometriosis)				
Gynecological Conditions (Fibroids)				
Gynecological Conditions (Other)				
Heart Attack				
Hepatitis – Type A				
Hepatitis – Type B				
Hepatitis – Type C				
Hepatitis – Other				
High Blood Pressure				
High Cholesterol				
Hip Fracture				
Irritable Bowel Syndrome				
Kidney Disease / Failure				
Kidney Stones				
Liver Disease				
Migraine Headaches				
Osteoporosis				
Pneumonia				
Prostate (enlargement)				
Prostate (nodules)				
Seizure / Epilepsy				

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Condition (Continue)	*Code*	*Current*	*Past*	*Comments*
Skin Condition (Eczema)				
Skin Condition (Psoriasis)				
Skin Condition (Abnormal Moles)				
Sleep Apnea				
Stomach Ulcer				
Stroke				
Thyroid (Nodule)				
Thyroid High (Overactive) / Hyperthyroidism				
Thyroid Low (Underactive) / Hypothyroidism				
Other (list)				
Other (list)				

SURGICAL HISTORY – Please check off any procedure or surgeries. List any abnormal finding or complications.

Surgical Procedure	*Code*	*Yes*	*Year*	*Comments*
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy				Circle: Right Left Both
Breast Surgery				Circle: Right Left Both
Colonoscopy				
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				Circle: Laparoscopic
Heart Surgery (other than coronary bypass)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal
Knee Surgery				Circle: Right Left Both
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation (“Tubal”)				
Ovary Removal				Circle: Right Left Both
Vasectomy				
Sigmoidscopy				
Sinus Surgery				
Other (list)				

Adopted – Yes No (Please Circle) If yes and you do <u>not</u> know your family history skip this section and continue to page 5 (Other Health Issues)

FAMILY HISTORY – Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom’s Mom	Mom’s Dad	Dad’s Mom	Dad’s Dad	Other Relative	Comments
No significant history known										
Alcoholism / Drug abuse										

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Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure -										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

OTHER HEALTH ISSUES:

Tobacco Use: (If you never used tobacco products, please go to next section)

Smoke cigarettes: Never:____ Yes: ____ No: ____

Quit date: _____ How many years did you smoke? _____Approximately; how many packs a day did you smoke? _____

Current smoker: Packs/day: _____ # of years: _____Other tobacco: _____ Pipe _____Cigar _____Snuff _____Chew

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Alcohol Use: (If you never used alcohol, please go to next section)

Do you drink alcohol? Never:_____ Yes: _____ No: _____

Number of drinks/week: _____ Beer: _____ Wine: _____ Liquor: _____

Drug Use: (If you never used any drugs, please go to next section)

Do you use marijuana or recreational drugs? Never:_____ Yes: _____ No: _____

Have you ever used needles to inject drugs? Never:_____ Yes: _____ No: _____

Sexual Activity:

Sexually involved currently: Yes: _____ No: _____

Sexual partner(s) is/are/have been: Male:____ Female: ____

Birth control method (check all that apply): None: ____Pill: ___ diaphragm:____ Condom____ vasectomy ____

Exercise:

Do you exercise regularly? _____ Yes _____ No what kind of exercise? _____

_____How long (minutes): _____How often: _____

Diet:

How would you rate your diet? _____Good _____Fair _____Poor
Would you like advice on your diet? _____No _____Yes

SOCIAL HISTORY:

Occupation (or prior occupation):_____ retired _____unemployed _____leave of absence _____disabled _____

Employer:_____ Years of education or highest degree: _____

Marital status (check one): _____ single _____ partner_____ married_____ divorced_____ widowed _____ other:

Spouse/partner's name: _____ Number of children: _____ Ages if under 18 years: _____

Number of grandchildren: _____ Number of great grandchildren: _____ Who lives at home with you? _____

Leisure activities, group involvement, religion, volunteer work, recent travel: _____

_____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births:_____ Date (month/day if known) of last menstrual period if you are still menstruating: _____ Age at beginning of periods (menstruation): _____ Age at end of periods (menopause): _____