****

| ***HEALTH HISTORY FORM -*** *ADULT - Primary Care appts* |
| --- |

**Date:**\_\_\_\_/\_\_\_\_/\_\_\_**Patient’s Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Chart#:**\_\_\_\_\_\_\_\_\_\_

**Current Concerns / New Problems:** 𝥁No concerns 𝥁Establish care with a new Primary Care Provider.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Health History: Have you had any of the following medical conditions?**

* Acid reflux
* Anemia (low blood count)
* Anxiety / Panic attacks
* Arthritis
* Asthma
* Blood clotting problems
* Cancer (Type: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

* Chronic back pain
* Constipation
* COPD / Emphysema
* Dementia / Alzheimer’s
* Depression
* Diabetes / High blood sugar
* Erectile dysfunction
* Eye disorder (Specify:\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

* Fibromyalgia
* Gout
* Gynecological problems (Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

* Hearing loss
* Heart disease / Heart attack
* Heart Failure
* Heart murmur
* High blood pressure
* High cholesterol
* Irregular heart beat / palpitations
* Joint problems (Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

* Kidney problems

(Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

* Liver problems
* Migraines / Chronic headaches
* Mobility problems
* Osteoporosis
* Prostate problems
* Seasonal Allergies
* Seizures
* Sexually transmitted disease
* Skin condition

(Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

* Stomach / GI problems

(Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

* Stroke / TIA
* Substance or alcohol abuse
* Thyroid problems
* Urinary incontinence
* Urinary tract infections
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any of the following surgeries?**

* Appendectomy
* Back surgery
* Biopsy (Type:\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

* Breast surgery
* Carotid artery surgery
* Cataract surgery
* Coronary artery bypass
* Colon surgery (Type:\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* C-Section(s)
* Dilation & Curettage (D&C)
* Gallbladder removal
* Gastric bypass / Weight loss surgery
* Heart stent(s)
* Hemorrhoidectomy
* Hernia repair (Type:\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

* Hysterectomy
* Joint replacement

(Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )

* Pacemaker insertion
* Prostate surgery
* Tonsillectomy
* Skin graft
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Page 1 of 2** *(Health History Form)*

**Prior Hospitalizations:**

Year: \_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year: \_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year: \_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year: \_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** **Please include name of medication or food and type of reaction**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications: Please include prescription medications, over-the-counter drugs, vitamins and supplements**

**Name / Dose # Tabs / Frequency Name / Dose # Tabs / Frequency**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History: Please indicate if any of the following conditions are present in your family members**

| **Relative**  | **Status** | **Cancer****(Specify Type)** | **Diabetes** | **Heart Disease** | **High Blood Pressure** | **Mental Illness (Specify)** | **Stroke** | **Other****(Specify)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Father | 𝥁 Alive𝥁 Deceased |  | 𝥁 | 𝥁 | 𝥁 |  | 𝥁 |  |
| Mother | 𝥁 Alive𝥁 Deceased |  | 𝥁 | 𝥁 | 𝥁 |  | 𝥁 |  |
| Siblings\_\_\_\_\_\_\_\_\_\_\_\_ | 𝥁 Alive𝥁 Deceased |  | 𝥁 | 𝥁 | 𝥁 |  | 𝥁 |  |
| Children\_\_\_\_\_\_\_\_\_\_\_\_ | 𝥁 Alive𝥁 Deceased |  | 𝥁 | 𝥁 | 𝥁 |  | 𝥁 |  |
| Other Family Members\_\_\_\_\_\_\_\_\_\_\_\_ | 𝥁 Alive𝥁 Deceased |  | 𝥁 | 𝥁 | 𝥁 |  | 𝥁 |  |

**CHECK YOUR PATIENT PORTAL TO REQUEST FUTURE PRESCRIPTION REFILLS,**

**CHECK LAB RESULTS & MORE!**

| **SIGNATURE** *(Patient / Legal Guardian)* |  |
| --- | --- |

*\*FOR OFFICE USE\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\**

*𝥁Allergies Reconciled? 𝥁Medications Reconciled? 𝥁Problem List Reconciled? 𝥁Patient Education provided via portal?*

***Page 2 of 2*** *(Health History Form)*

4551 New Bern Avenue, Ste. 160 | 3350 Six Forks Rd |Raleigh, NC | ph: 919.556.1008 | fax: 919.556.6099