KOCH FAMILY MEDICINE

PATIENT HEALTH HISTORY

Date: / / *Please CIRCLE answers and PRINT all information*

Name: Birthdate: / /

Phone: (_____) _____- _____ May we leave a brief message? Yes No

Marital Status: Single Married Divorced Widowed Racial/Ethnic Background: _____

Occupation: _____ Retired? Yes No

Date of Last Physical: _____ /_____ /_____ Where: _____

MEDICAL HISTORY: Have you ever been treated for any of the following medical conditions?

Arthritis	Cancer	Depression/Anxiety	Diabetes	Heart Problems	High Blood Pressure
High Cholesterol	Irritable Bowel	Lung Problems	Osteoporosis	Thyroid Problems	

IMMUNIZATIONS:

Date of Last: Flu _____ Pneumonia _____ Tdap / Td _____ Shingles Shingrix _____

MEDICATIONS: Clinical staff will review with patient.

Do you taken any supplements (calcium/vitamin D/fish oil/multivitamin)? Y N

ALLERGIES (including Latex): _____

PAST SURGERIES: _____

NUTRITIONAL SCREENING QUESTIONS:

=> Have you lost more than 10 lbs in the last 6 months without trying? Y N

=> Do you have any open sores that are not healing? (decubitis) Y N

=> Are you having difficulty chewing or swallowing that is affecting your food intake? Y N

FAMILY HISTORY: Please list any known medical problems for the relatives listed below:

(For example: diabetes, breast/colon/ovarian/prostate cancer, heart attacks, high blood pressure, alcohol abuse, depression, skin cancer, osteoporosis.)

Mother: _____

Father: _____

Brothers/Sisters: _____

Children: _____

Other: _____

HABITS:

What do you do for exercise? _____

How often? _____

Tobacco (chew / smoke): _____ per day

Alcohol (beer / wine, etc.): _____ per day

Street drugs (marijuana, etc.): _____ per day

Caffeine (coffee / tea / soda): _____ per day

Any trouble sleeping? Y N

Describe your eating habits (poor, well-balanced, vegetarian, gluten-free, etc.): _____

Do you have a Living Will? Y N Do you have a healthcare Durable Power of Attorney? Y N

Have you provided this office with a copy? Y N Would you like more information? Y N

KOCH FAMILY MEDICINE

PATIENT HEALTH HISTORY

Name: Birthdate: / /

REVIEW OF SYSTEMS

Please CIRCLE answers and PRINT all information

General Symptoms:
Fever, unexplained tiredness, swollen glands, excessive thirst, feeling unusually hot or cold, easy bruising or bleeding, passing out

Eyes:
Vision loss, eye pain, blurred vision

Ears/Nose/Mouth/Throat:
Sore throat, runny nose, hearing loss, problems with mouth, voice changes

Breasts:
Lumps, skin changes, nipple discharge

Lungs & Heart:
Chest pain/pressure, irregular heart beat, cough, wheezing, breathing trouble

Skin:
Rashes, changing moles, changes in hair/skin/nails

Neurological:
Unusual or new headaches, weakness or numbness, falling

Abdomen:
Nausea, vomitting, pain, heartburn, diarrhea, constipation, bloody stools

Sleep:
Difficulty falling asleep, frequent awakening

Musculoskeletal:
Joint/muscle pain, muscle weakness

Mood:
Worry too much, felt down and depressed in the last two weeks, loss of desire to do things you used to enjoy, thoughts of self harm or suicide

MEN ONLY:
Difficulty starting or weak stream, difficulty getting/maintaining erections, feeling like bladder won't empty, getting up at night to urinate, testicular pain/lumps, possible sexually transmitted infections

WOMEN ONLY:
Heaving periods, bleeding after menopause, sexual concerns, unusual vaginal discharge, possible sexually transmitted infections, severe pain with periods, leaking urine

Still having periods? Y N
Regular Irregular
Date of last period? _____
Have you ever had an abnormal pap or colposcopy? Y N

Birth control type: _____

Hysterectomy? Y N
If yes, what age? _____
Reason? _____
Ovaries present? Y N

Number of pregnancies? _____
Vaginal deliveries? _____
C-section deliveries? _____
Other? _____
(stillbirth, miscarriage, abortion)
Diabetes during pregnancy? Y N

OTHER:
List any symptoms not mentioned:

_____

_____

SPECIALISTS: _____

_____

_____

_____

_____

_____

Mammogram: _____

Last PAP: _____

Chlamydia Screening: _____

Bone Density: _____

Fasting Labs: _____

Colonoscopy: _____