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Johnson City, TN 37601

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HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.
All questions contained on this form are strictly confidential & will become part of your medical record.

Date: ____________________

Patient Name:____________________________ **Sex:** M F **Date of Birth:** ____________________

Martial Status: Single Partnered Married Separated Divorced Widowed

Referring Doctor:________________________________ **Date of Last Physical Exam:** ____________________

Chief Compliant:____

PERSONAL HEALTH HISTORY

Have you ever had the following (circle "no" or "yes", leave blank if uncertain)?

Measles	yes	no		Seasonal Allergies	yes	no
Mumps	yes	no		HIV/AIDS	yes	no
Chicken Pox	yes	no		Ear Problems	yes	no
Rheumatic Fever	yes	no		Eye disorder/Glaucoma	yes	no
Polio	yes	no		Seizures	yes	no
Heart Disease/ Murmur/Angina	yes	no		Stroke	yes	no
High cholesterol	yes	no		Headaches/Migraines	yes	no
High Blood Pressure	yes	no		Neurological problems	yes	no
Low Blood Pressure	yes	no		Depression / Anxiety	yes	no
Heartburn (reflux)	yes	no		Psychiatric care	yes	no
Anemia or blood problems	yes	no		Diabetes	yes	no
Swollen ankles	yes	no		Kidney / Bladder problems	yes	no
Shortness of breathe	yes	no		Liver problems/Hepatitis	yes	no
Asthma	yes	no		Arthritis	yes	no
Lung Problems/cough	yes	no		Cancer	yes	no
COPD	yes	no		Ulcers/colitis	yes	no
Thyroid problems	yes	no		Bleeding Tendency	yes	no
Mitral Valve Prolapse	yes	no				
Others	yes	no		Please Explain:		

Previous Hospitalizations/Surgeries/Serious Illness

Reason	When	Hospital, City, State.	Name of the Physician
Have you ever had a blood transfusion or tattoo?	yes no		
Any body piercing?	yes no		

	Have you ever given yourself street drugs with a needle	yes	no	
Sex	Are you sexually active	yes	no	
	Sexual Preference	M	F	
	If yes, are you trying for a pregnancy	yes	no	
	If not, list contraceptive method used	yes	no	
	Any discomfort with intercourse	yes	no	
	Illness related to the HIV, such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use & unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness	yes	no	
		yes	no	
Personal Safety	Do you live alone	yes	no	
	Do you have frequent falls	yes	no	
	Do you have vision or hearing loss	yes	no	
	Do you have an Advance Directive and/or Living Will?	yes	no	
	Would you like information on the preparation of these?	yes	no	
		yes	no	
	Physical and/or mental abuses have also become major public health issues in this country. This often takes the form of verbally threatening behavior and/or actual physical /sexual abuse. Would you like to discuss this issue with your provider	yes	no	

FAMILY HEALTH HISTORY

		Age	Age@ Death	Significant Health Issues or Cause of Death
Father				
Mother				
Siblings	M F			
	M F			
	M F			
	M F			
Children	M F			
	M F			
	M F			
	M F			
Grandparents (Father's side)				
Grand Father				
Grand Mother				
Grandparents (Mother's side)				
Grand Father				
Grand Mother				

MENTAL HEALTH

Is stress a major problem for you	yes	no
Do you feel depressed	yes	no
Do you panic when stressed	yes	no
Do you have problems with eating or your appetite	yes	no
Do you cry frequently	yes	no
Have you ever attempted suicide	yes	no
Have you ever seriously thought about hurting yourself	yes	no
Do you have trouble sleeping	yes	no
Have you ever been to a psychologist/counselor	yes	no

WOMEN ONLY

Age at onset menstruation		
Date of last menstruation		
Period every ( ) # of days. Heavy periods, irregularity, spotting , pain or discharge		
( ) # of pregnancies. ( ) # of live births		
Are you currently pregnant or breastfeeding	yes	no
Have you had D&C, hysterectomy, or Cesarean section	yes	no
Any urinary tract, bladder, or kidney infections within last year	yes	no
Any blood in your urine	yes	no
Any problems with control of urination	yes	no
Any hot flashes or sweating at night	yes	no
Do you have menstrual tension, pain bloating, irritability, or other symptoms at or around time of period	yes	no
Experienced any recent breast tenderness, lumps, or nipple discharges	yes	no
Date of last pap smear and rectal exam?	yes	no

MEN ONLY

Do you usually get up to urinate during the night	yes	no
If yes, ( ) # of times		
Do you feel pain or burning with urination		
Any blood in your urination		
Do you feel burning discharge from penis	yes	no
Has the force of your urination decreased	yes	no
Have you had any kidney, bladder, or prostate infections within the last 12 months	yes	no
Do you have any problems emptying your bladder completely	yes	no
Any difficulty with erection or ejaculation	yes	no
Any testicle pain or swelling	yes	no
Date of the last prostate and rectal exam	yes	no

IMMUNIZATIONS RECORD

Name	Date	Name	Date
Tetanus		Pneumonia	
Hepatitis		Chicken Pox	
Influenza		MMR (Measles, Mumps, Rubella)	

Medication (including non – prescription)

Name of Medication	Strength	Frequency Taken

Allergies to Medications

Names of Medication	Reactions you had

HEALTH HABITS AND PERSONAL SAFETY

Occupation / Job ________________________________

Exercise	Never			
	Occasionally (less than3 times x 30 min. /wk)			
	Regularly (more than 4 times x 30 min./wk)			
Diet	Are you dieting	yes	no	
	If you are, are you on a physician prescribed medical diet?	yes	no	
	Rank Salt Intake (please circle one) Hi Med Low			Rank Fat Intake (please circle one) Hi Med Low
Caffeine	Never			
	Coffee Tea Soft Drinks			( ) # of cups (8 oz) / ( )# of cans per day
Alcohol	Do you drink alcohol?	yes	no	
	Kind of Drinks Please List:			
	Amount of consumption			( ) of glasses per week or month or year
	Are you concerned about the amount you drink?	yes	no	
	Have you considered stopping?	yes	no	
	Have you ever-experienced blackouts?	yes	no	
	Are you prone to “binge” drinking?	yes	no	
	Do you drive after drinking	yes	no	
Tobacco	Do you use Tobacco	yes	no	
	Cigarettes - ( ) # of packs per day			Chew - ( ) # per day
	Pipe - ( ) # per day			Cigars - ( ) # per day
	# of years used- ( )			# of year quit – ( )
Drugs	Do you currently use recreational drugs	yes	no	