Health History Data Sheet

Current Health

Height:__________ Weight:________ ☐ Per CRC scale

B/P:____________ Pulse: __________

What prompted this visit?________________________________

Family MD:________________ Cardiologist:_______________

Neurologist:Yes/No________________________________

MD requesting consultation:___________________________

Yes	No	History of Present Illness
☐	☐	Blood with Bowel movement
☐	☐	Enough blood to turn toilet water red
☐	☐	Rectal irritation and itching
☐	☐	Hemorrhoidal bleeding
☐	☐	Hemorrhoidal swelling
☐	☐	Rectal Pain
☐	☐	Constipation
☐	☐	Black tarry stools
☐	☐	Loose or Frequent Stools
☐	☐	Abdominal pain, bloating, cramping
☐	☐	Stomach pain after eating
☐	☐	Nausea, vomiting
☐	☐	Difficulty swallowing
☐	☐	Heartburn/indigestion
☐	☐	Other symptoms: ____________
☐	☐	Allergy to egg or soy
☐	☐	Allergy to Latex
☐	☐	Allergy to peanut products

	Name/dose/frequency taken	None
Drug allergies		☐
Narcotics used last 10 years		☐
Current Medications (if more than 3 medications, please write on attached sheet)		☐
Over the counter medications		☐
Aspirin	☐ Baby 81mg ☐ Adult 325mg How often do you take? ______	☐

	Current Medical Problems	None
Constitution:	☐ Lack of appetite ☐ Chills/Fever	☐
Endocrine	☐ Weight loss	☐
Eyes:	☐ Vision changes	☐
Lungs:	☐ Difficulty breathing ☐ Active TB ☐ Wheezing ☐ Chronic cough	☐
Heart :	☐ Chest pain on exertion	☐
Stomach:	☐ Spitting up blood	☐
Blood:	☐ Bleeding tendency ☐ Anemia	☐
Urinary:	☐ Blood in urine ☐ Hesitancy ☐ Painful urination ☐ Incontinence	☐
Muscle/skeletal:	☐ Arthritis ☐ Back pain	☐
Skin:	☐ Skin rash/hives	☐
ENT:	☐ Sore throat	☐
Allergy/immunology	☐ Seasonal allergies	☐

Annual Health Review

Yes	No	
☐	☐	Stroke, Date:______________________
☐	☐	Seizures: Date of last seizure:______________
☐	☐	Emphysema:
☐	☐	COPD
☐	☐	Sleep Apnea CPAP use: ☐ Yes ☐ No
☐	☐	Oxygen dependent
☐	☐	Asthma
☐	☐	Angina Use Nitroglycerin? ☐ Yes ☐ No
☐	☐	Heart Murmur / Need antibiotics @ dentist? ☐ Yes ☐ No
☐	☐	Heart attack Date: ________________
☐	☐	Pace Maker Date placed: ______________
☐	☐	Congestive Heart Failure EF% ______
☐	☐	Irregular heart beat
☐	☐	High blood pressure
☐	☐	Replaced heart valve: Date: ______________
☐	☐	Rheumatic Heart Fever/Previous endocarditis Date: _______
☐	☐	Arterial Grafts or stents Date placed: ____________
☐	☐	Mitral Valve Prolapse/ Congenital heart defect
☐	☐	History of inflammatory bowel disease (Crohn's, colitis etc)
☐	☐	Cancer/Location: ________________
☐	☐	HIV positive
☐	☐	Anemia
☐	☐	Diabetes, (diet controlled or medication)
☐	☐	Kidney disease: ________________
☐	☐	Prostate problems:________________
☐	☐	Liver disease:________________
☐	☐	Implants or Artificial Joints: Where:_________When:______
☐	☐	Malignant Hyperthermia
☐	☐	Other medical problems:______________

Surgery History

Yes	No	
☐	☐	Hemorrhoidectomy When:______________
☐	☐	Appendectomy
☐	☐	Stomach operation
☐	☐	Gallbladder operation
☐	☐	Spleen removed
☐	☐	Colon operation When:______________
☐	☐	Hysterectomy
☐	☐	Heart Surgery: Type: ______________When________
☐	☐	Colon polyp/ When______________
☐	☐	Colonoscopy: when /by whom: ____________
☐	☐	Other surgeries:______________

Social and Family History

Yes	No	
☐	☐	Do you drink alcohol? ☐ Social ☐ Moderate ☐ Heavy
☐	☐	Do you smoke? Packs per day________#years__________
☐	☐	Have you ever used recreational drugs? Type: ________
☐	☐	Do you have any disabilities? List:______________
☐	☐	Family with cancer? Who: __________ Type: ________
☐	☐	Family with polyps? Who:______________
☐	☐	Mother Alive: Cause,of death:______________
☐	☐	Father: Alive: Cause of death: ______________

Your occupation: ______________________________

This information is true and correct to the best of my belief

Patient/Guardian Signature ______________________________ Date: ______________

Printed Name: ______________________________ Date of Birth: ______________

Center use only

Updated: __________ ______________________________ ______________

Date Patient/Guardian Signature MD initial