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Chart #:_____
Telephone: 919.571.6465
Facsimile: 919.571.6455

Date:_____ Physician:_____

Health History Assessment

Name:_____ Birth Date:_____

Address:_____

Allergies (Medicine, Food, Latex, etc.)/Reactions:_____

Current Medications (Include medications taken for sleep and as a laxative)

Medication	Dose	Frequency Taken	Medication	Dose	Frequency Taken

Present/ Previous Health Problems: (For family boxes, indicate for mother, father, sister, brother, children)

	Self	Family		Self	Family
Stroke	☐	☐			
Diabetes	☐	☐	Leg/Back/Neck Pain	☐	☐
Heart Problems	☐	☐	Hiatal Hernia	☐	☐
Arthritis	☐	☐	Convulsions/Seizures	☐	☐
Breathing Problems	☐	☐	Kidney Disease	☐	☐
High Blood Pressure	☐	☐	Bleeding Problems	☐	☐
Cancer	☐	☐	Depression/Mental Illness	☐	☐
Hepatitis	☐	☐	HIV/AIDS	☐	☐
Thyroid	☐	☐	Phlebitis/Blood Clots	☐	☐

List Surgeries/Hospitalizations with Dates:_____

List Previous and Current Conditions Being Treated for (ex. High blood pressure, diabetes):_____

Please list the dates of your last:

Mammogram_____ Tetanus Shot_____ Cholesterol Test_____
Flexible Sigmoid_____ Flu Shot_____ TB Skin Test_____
Chest XRay_____ Pneumonia Shot_____ MMR_____
EKG_____ Hepatitis B Shot_____

Health History Assessment

Do you have and advanced directive? ☐ Living Will ☐ Health Care Power of Attorney ☐ No

Do you wear: ☐ Glasses ☐ Contacts ☐ Hearing Aids

Use of Tobacco: ☐ No ☐ Stopped When_____

☐ Cigarettes _____ Packs/day for # years _____ ☐ Pipe ☐ Cigar ☐ Chewing Tobacco ☐ Snuff

Use of Alcohol: ☐ No ☐ Occasionally ☐ Daily

Do you drink caffeine? ☐ Yes ☐ No

Where do you live? ☐ House ☐ Apartment ☐ Retirement Home ☐ Other _____

Do you live alone? ☐ Yes ☐ No ☐ With Family ☐ Other _____

Resources/support persons available to assist you: ☐ Spouse ☐ Other_____

Has there been a change in your marital status in the last year? ☐ No ☐ Yes _____

Has there been a death in your family in the last year? ☐ No ☐ Yes _____

Do you utilize: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Artificial Limb

Do you need assistance with: ☐ Eating ☐ Walking ☐ Dressing ☐ Other _____

Have you had any problems with eating or drinking in recent weeks? ☐ No ☐ Yes

Problems with swallowing? ☐ No ☐ Yes ☐ Solids ☐ Liquids ☐ Pills

Unplanned weight gain or loss of 10 pounds or more in last 6 months or 5 pounds in one month? ☐ No ☐ Yes

☐ Loss ☐ Gain _____ Pounds in _____ months

Do you have tooth or mouth problems that make it hard for you to eat? ☐ No ☐ Yes

Describe: _____

Do you have: ☐ Dentures ☐ Bridges ☐ Caps ☐ Loose Teeth

Do you eat fewer than 2 meals per day? ☐ No ☐ Yes

Are you on a special diet or supplement? ☐ No ☐ Yes

Do you exercise? ☐ No ☐ Yes Frequency_____ Type_____

Do you have trouble tolerating activity? ☐ No ☐ Yes Why?_____

Do you have any special requests due to your religious practices/culture/values? ☐ No ☐ Yes

☐ Special Diet ☐ Blood Transfusion ☐ Other_____

Explain above _____

Religious Affiliation _____

Education: Last grade completed: _____

Present Occupation: _____

If Retired, what was your previous employment?_____

How do you learn best? ☐ Reading ☐ TV/Video ☐ Demonstration ☐ Listening ☐ Doing

Do you have difficulty understanding and reading written materials? ☐ No ☐ Yes

Do you have a need for education about health or disease topics? ☐ No ☐ Yes Topic_____

Systems Review

A. General	**Yes**	**No**	**Comments**
1. Do you worry about your health?	☐	☐	
2. Do you usually feel tired?	☐	☐	
3. Do you feel that stress is adversely affecting your health?	☐	☐	
B. Skin *Have you noticed:*			
1. Skin rashes or itching	☐	☐	
2. Growths on the skin	☐	☐	
3. Sores that do not heal	☐	☐	
4. Change in the color or size of moles	☐	☐	
C. Eyes *Have you noticed:*			
1. Blurred vision	☐	☐	
2. Double vision	☐	☐	
3. Draining or itching eyes	☐	☐	
4. Pain in your eyes	☐	☐	
5. Glaucoma check in past year	☐	☐	
D. ENT *Have you had:*			
1. Difficulty hearing	☐	☐	
2. Ringing in your ears	☐	☐	
3. Nasal stuffiness or drainage	☐	☐	
4. Frequent or severe nosebleeds	☐	☐	
5. Mouth sores that do not heal	☐	☐	
6. Recurrent sinus infections	☐	☐	
E. Respiratory *Have you had:*			
1. Difficulty breathing	☐	☐	
2. To sleep on more than one pillow #_____	☐	☐	
3. Waking up short of breath	☐	☐	
4. A constant cough	☐	☐	
5. Coughing up blood	☐	☐	
6. Wheezing in your chest	☐	☐	
7. Exposure to tuberculosis	☐	☐	
8. Recurrent history of Bronchitis	☐	☐	
9. Recurrent history of Pneumonia	☐	☐	
F. Cardiovascular *Have you had:*			
1. Pain/pressure in your chest, jaw, arm with exercise	☐	☐	
2. Palpitations of your heart at rest or during exercise	☐	☐	
3. A previous heart murmur	☐	☐	
4. Swelling in your ankles	☐	☐	
5. Cramps/pain in legs with walking	☐	☐	
6. Changes in the color of your fingers or toes	☐	☐	
7. History of high blood pressure	☐	☐	
8. History of abnormal EKG	☐	☐	
G. Musculoskeletal *Have you had:*			
1. Pain in joints	☐	☐	
2. Swelling in joints	☐	☐	
3. Morning stiffness in joints	☐	☐	
4. Pain in joints in cold weather	☐	☐	
5. Pain in lower back which interferes with activities	☐	☐	

H. Gastrointestinal *Have you had:*	**Yes**	**No**	**Comments**
1. Any change in appetite	☐	☐	
2. Any weight changes recently	☐	☐	
3. Difficulty swallowing	☐	☐	
4. Abdominal or stomach pains	☐	☐	
5. Food intolerances (to fatty, greasy, spicy foods)	☐	☐	
6. Vomiting of blood	☐	☐	
7. Black or tarry stools	☐	☐	
8. Blood in stools	☐	☐	
9. Diarrhea in the last 3 months	☐	☐	
10. Constipation on regular basis	☐	☐	
11. Regular use of laxatives	☐	☐	

I. Urinary *Have you had:*			
1. Difficulty with urination	☐	☐	
2. Burning or pain with urination	☐	☐	
3. Hesitation with urination	☐	☐	
4. Getting up at night to urinate more than one time	☐	☐	
5. Blood in urine	☐	☐	
6. Loss of urine with cough/sneeze	☐	☐	
7. Problems with sexual function	☐	☐	
8. **(Men)** Prostate gland trouble	☐	☐	

J. Nervous System *Have you had:*			
1. Frequent or severe headaches	☐	☐	
2. Dizziness or light headedness	☐	☐	
3. Episodes of fainting	☐	☐	
4. Seizures or convulsions	☐	☐	
5. Difficulty remembering recent events	☐	☐	
6. Episodes of crying	☐	☐	
7. An urge to commit suicide	☐	☐	
8. Difficulty sleeping	☐	☐	
9. Frequent feeling of agitation or loss of control	☐	☐	
10. Tingling or numbness in arms or legs	☐	☐	
11. Trouble sleeping	☐	☐	
12. Difficulty with balance, coordination or weakness	☐	☐	

K. Gyn (Women Only) *Have you had:*			
1. Regular monthly periods (Date last period:_____)	☐	☐	
2. Spotting/bleeding between your periods	☐	☐	
3. Heavy bleeding with your periods	☐	☐	
4. Pain or cramping with you periods	☐	☐	
5. Bloating/ irritability before your period	☐	☐	
6. Use birth control (Form:_____)	☐	☐	
7. Hot Flashes	☐	☐	
8. Have you passed menopause	☐	☐	
9. Vaginal Discharge	☐	☐	
10. Monthly breast self-exam	☐	☐	
11. Hormone therapy	☐	☐	

Number of Pregnancy's_____
Number of Children born Alive _____
Number of Miscarriages _____
Number of Stillborns _____
Number of C-Sections _____

Complications with Pregnancies: _____

Completed By:_____

Relationship to Patient:_____