

Patient Health Review

Confidential

PLEASE PRINT ALL INFORMATION CLEARLY

To be completed at first visit and during annual update

If you need help complete this form, please let us know, we will be happy to help you. Si necesitas ayuda en completar esta planilla, por favor dejenos saber. Estaremos contento en ayudarle.

Today's Date: _____

Print Your Name: _____

Date of Birth: _____

Occupation: _____

Are you ALLERGIC to any medications? If yes, please list below:

Medical History:

Please check any of these that you have had or are currently being treated for

- | | | |
|----------------------|---------------------------|--------------------------|
| _____ Alcohol Abuse | _____ Diabetes | _____ Kidney Disease |
| _____ Anemia | _____ Drug Abuse | _____ Kidney Stones |
| _____ Anxiety | _____ Emphysema | _____ Pneumonia |
| _____ Arthritis | _____ Gout | _____ Rheumatic Fever |
| _____ Asthma | _____ Heart Disease | _____ STD |
| _____ Blood Disorder | _____ Hepatitis | _____ Thyroid Disease |
| _____ Cancer | _____ High Blood Pressure | _____ Tuberculosis (TB) |
| _____ Colitis | _____ High Cholesterol | _____ Ulcers |
| _____ Depression | _____ HIV/AIDS | _____ Urinary Infections |

Please give us more detail on any checked item(s):

OBSTETRIC & GYNECOLOGICAL HISTORY:

How many: _____ Pregnancies _____ Births _____ Miscarriages

When was your last menstrual period: _____

PREVENTION: When was you last:

Pap Smear: _____ Mammogram: _____ Breast Exam: _____

Please check any that apply:

- | | |
|--------------------------------------|--------------------------|
| _____ Prolonged or abnormal bleeding | _____ Leakage of urine |
| _____ Abnormal Discharge | _____ Abnormal pap smear |
| _____ Pain in Pelvic Area | |

Please give us more detail on any checked item(s):

PREVENTION SERVICES: (continued on second page)

When was your last:

Prostate exam: _____ Eye Exam _____ Sigmoidoscopy: _____ Colonoscopy: _____

Hospitalizations other than for surgery (List reason and date):

PREVENTION SERVICES:

Have you had these vaccines:

Hepatitis B No: _____ Yes: _____ When: _____
 Hepatitis A No: _____ Yes: _____ When: _____
 Pneumovax No: _____ Yes: _____ When: _____
 Tetanus No: _____ Yes: _____ When: _____
 If born after 1957: Measles or MMR No: _____ Yes: _____ When: _____

Family History:

Has any member of our immediate family (parents, brothers, sisters, children) had any of the following:

- Cancer (Type)
- High Blood Pressure
- Heart Disease (Type)
- Diabetes
- Stroke
- Glaucoma
- Bleeding Problems
- Drug or Alcohol Abuse
- Emotional Problems (Type)

MEDICATIONS: Please indicate all Prescriptions, non-prescription medications, including vitamins, and birth control pills

Medication Name:	Dosage:	How Often

PREVENTION SURVERY:

Do you wear seatbelts? _____ No _____ Yes If no, why not? _____
 Do you wear a bicycle helmet? _____ No _____ Yes If no, why not? _____
 Do you exercise? ___ No ___ Yes. If yes, how often & what kind? _____
 Do you smoke? ___ No ___ Yes. If yes, how many pack per day? _____ How many years? _____
 Do you drink alcohol? ___ No ___ Yes. If yes, how many drinks per week? _____
 Is there a gun in your home? _____ Is yes, is it out of children's reach? _____ Is it unloaded? _____
 Do you use recreational drugs? _____ No _____ Yes. If yes, what kind and how often? _____

Have you ever engaged in any activity which has put you at risk for getting HIV/AIDS? No _____ Yes _____
 If yes, please explain: _____

Would you like to be tested for HIV/AIDS? _____ No _____ Yes
 Have you ever worked with chemicals, paints, asbestos or other hazardous materials? ___ No ___ Yes
 Are you in a relationship where you have been hurt by your partner, child, parent or caregiver? ___ No ___ Yes
 Are you afraid of you partner, child, parent or caregiver? _____ No _____ Yes
 Do you have a living will, advance directive, or proxy statement? _____ No _____ Yes
 Do you have an organ donor card? _____ No _____ Yes
 What method of birth control do you and your partner(s) use? _____