Complete both pages

Saint Alphonsus Medical Group

Today's date:_____

ANNUAL HEALTH HISTORY

Name:_____ Age:_____ Date of last physical exam: _____

Symptoms: Do you have any of the following?

GENERAL CONSTITUTION
__ Appetite decreased
__ Appetite increased
__ Chills/Rigors
__ Dizziness
__ Fainting
__ Fatigue/Malaise
__ Fever
__ Sleeping difficulties / Insomnia
__ Swollen glands
__ Weight gain, unplanned
__ Weight loss, unplanned
__ Other:_____

HEENT
Head
__ Headache
__ Neck lumps/swelling
__ Other:_____
Eyes
__ Blurred vision
__ Double vision
__ Eye changes
__ Other:_____
Date of last eye exam:
_____
Ears
__ Earache
__ Hearing loss / Difficulty
__ Other:_____

Nose
__ Hayfever
__ Sinusitus
__ Other:_____
Throat & Mouth
__ Hoarseness
__ Mouth sores
__ Teeth or gum problems
__ Other:_____
Date of last dental exam:
_____

RESPIRATORY
__ Chronic lung problems
__ Coughing blood
__ Frequent cough
__ Shortness of breath
__ Sleep apnea
__ Wheezing
__ Other:_____
Date of last CXR:_____

CARDIOVASCULAR
__ Artificial heart valves
__ Chest pains
__ History of blood transfer
__ Irregular / rapid heartbeat
__ Poor circulation
__ Swelling of ankles or feet
__ Varicose veins
__ Other:_____
Date of last EKG:
_____

GASTROINTESTINAL
__ Bloating
__ Bowel changes
__ Colitis
__ Constipation
__ Diarrhea
__ Difficulty swallowing
__ Excess belching
__ Gas
__ Heartburn
__ Hemorrhoids
__ Hiatal Hernia
__ Indigestion
__ Nausea
__ Nervousness
__ Pancreatitis
__ Rectal bleeding
__ Stomach pain
__ Stools black or tarry
__ vomiting
__ Vomiting blood
__ Other:_____
Date of Colonoscopy:
_____

GENITOURINARY
__ Blood in urine
__ Difficulty urination
__ Frequent urination
__ Kidney/bladder problems
__ Lack of bladder control
__ Other:_____

HEMATOLOGIC & ALLERGIES LYMPHATIC
__ Allergic disorders
__ Bleeding disorders
__ Cancer _____
__ Swollen glands
__ Other:_____

MUSCULOSKELETAL
Pain, stiffness, swelling in:
__ Arms __ Hips
__ Back __ Legs
__ Feet __ Neck
__ Hands __ Shoulders
__ Difficulty with balance
__ Difficulty with walking
Date of last fall:_____

SKIN
__ Bleed or bruise easily
__ Change in mole
__ Hives
__ Itching
__ Rash
__ Skin changes
__ Other:_____

NEUROLOGIC & PSYCHIATRIC
__ Depression or anxiety
__ Forgetfulness
__ Numbness
__ Weakness
__ Other:_____

MEN Only
__ Breast lump
__ Erection difficulties
__ Lump in testicles
__ Penis discharge
__ Prostate problems
__ Sore/warts on penis
Date of last PSA:_____

WOMEN Only
__ Abnormal menstrual periods
__ Abnormal Pap smear
__ Bleeding between periods
__ Breast Lumps
__ Extreme menstrual pain
__ Hot flashes
__ Painful intercourse
__ Vaginal discharge or itching
__ Other:_____
Date of last period:_____
Date of last Pap smear: _____
Date of last mammogram:
_____
Are you pregnant? No / Yes
Birth control? No / Yes
_____

CONDITIONS: Check conditions you have or have had in the past

__ AIDS
__ Alcoholism
__ Anemia
__ Anorexia
__ Appendicitis
__ Arthritis
__ Asthma
__ Bleeding disorder
__ Breast lump
__ Bronchitis
__ Bulimia
__ Cancer
__ Chemical dependency
__ Chicken pox
__ Diabetes
__ Emphysema
__ Epilepsy
__ Glaucoma
__ Colon cancer
__ Crohn's
__ Goiter
__ Gonorrhea
__ Gout
__ Heart attack
__ Heart disease
__ Heart problems
__ Hepatitis
__ Hernia
__ Herpes
__ High blood pressure
__ High cholesterol
__ HIV positive
__ Kidney disease
__ Liver disease
__ Measles
__ Migraine headaches
__ Miscarriage
__ Mononucleosis
__ Multiple sclerosis
__ Mumps
__ Pacemaker
__ Pneumonia
__ Polio
__ Prostate problems
__ Psychiatric care
__ Rheumatic fever
__ Scarlet Fever
__ Stomach ulcers
__ Stroke
__ Suicide attempt
__ Thyroid problems
__ Tonsillitis
__ Tuberculosis
__ Typhoid fever
__ Vaginal discharge
__ Vaginal disease

List doctors who currently treat you and the conditions treated:

_____
_____
_____

Patient and Provider need to Date/Time/Initial

Initial review by Provider: ____/____/____ Date / Time / Initial

Patient		Provider	
____/____/____ Date / Time / Initial		____/____/____ Date / Time / Initial	
____/____/____ Date / Time / Initial		____/____/____ Date / Time / Initial	
____/____/____ Date / Time / Initial		____/____/____ Date / Time / Initial	
____/____/____ Date / Time / Initial		____/____/____ Date / Time / Initial	

People assisting with paperwork:

Interpreter's Name _____ Interpreter's Signature and/or ID # _____ Date / Time _____

Office Staff Name _____ Office Staff Signature _____ Date / Time _____

Place Patient Sticker here or handwrite
Name: _____
DOB: _____

Saint Alphonsus Medical Group

ANNUAL HEALTH HISTORY PAGE 2

Medications and dosages:	**Allergies:**	
1.		
2.		
3.		
4.	**Hospitalizations:**	
5.	1.	2.
6.	3.	4.
7.	5.	6.
8.	**Surgeries:**	
Injuries:		

Immunization - When did you last have? (mm/yyyy)

Immunizations: Tetanus ____ Pneumonia _____ Flu _____ TB _____ Hepatitis B _____ Other _____

Family History (Circle check mark if cause of death.)

	Alcoholism	Asthma	Cancer	Depression	Diabetes	Emphysema	Glaucoma	Heart Attack or Angina	Heart Failure (Weak Heart)	High Blood Pressure	High Cholesterol	Migraine Headaches	Osteoporosis	Stroke	Thyroid Disease	Trouble with blood clotting	Age at Death
Father																	
Mother																	
Brothers																	
Sisters																	

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Spouse's Name:** _____
Living arrangements ☐ Alone ☐ Family/Significant Other ☐ Assisted Living ☐ Daily help needed for self care
Name of care giver _____ **Children:** How many? _____ Ages: _____

Occupation: _____ ☐ FT ☐ PT ☐ Self ☐ Retired from:_____
Level of Education: ☐ HS / GED ☐ Tech / A.A ☐ B.S. / B.A. or higher

Diet: ☐ Unrestricted ☐ Low fat ☐ Low carb / diabetic **Caffeine**:☐ No ☐ Yes Type/Amt: _____

Sleep: # of hours per night _____ **Problems:** Falling / Staying asleep? ☐ No ☐ Yes
Exercise: ☐ No ☐ Yes Type: _____ ☐ Once a week ☐ 2-3x/wk ☐ Daily

Activities of Daily Living:
Any difficulty with?
☐ Speech/Communication
☐ Memory ☐ Dressing
☐ Bathing ☐ Household Duties

Fall Risk: Do you have concerns about falling? ☐ No ☐ Yes Do you use any balance/mobility devices? _____
Learning Needs: Are there any needs (learning, ethnic, cultural, or spiritual) we should know about that might impact your care or your ability to understand treatments / procedures/ educational materials? ☐ No ☐ Yes Please explain: _____

Abuse / Neglect: Are you experiencing neglect and/or conflict in your family and/or relationships? ☐ No ☐ Past ☐ Current

Tobacco: ☐ Never ☐ Past ☐ Current
Started: _____ Quit: _____
Packs per day? _____ ☐Smoke ☐Chew

Alcohol: ☐ Never ☐ Past ☐ Current
_____ # of drinks per ☐ Day ☐ Week ☐ Month

Street Drugs: ☐ Never ☐ Past ☐ Current
What? _____
Started: _____ Quit: _____

Place patient sticker here or handwrite

Name: _____

DOB: _____