

BECKER FAMILY MEDICINE, S.C.
HEALTH HISTORY FORM

Welcome to our practice. Please fill out the information below to the best of your ability.

Today's Date: _____ Account: _____
 Patient Name _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Social Security No _____ Sex _____ Height _____ Weight _____
 Chief Complaint (Reason for your visit today): _____

Date Symptoms Began _____ Is It Related To Work or Auto Accident Yes/No

Primary Care Physician _____ Who Referred You? _____

Past Medical History

Have you ever had any of the following? Please check all pertinent boxes:

- | | | |
|---|--|--|
| <input type="checkbox"/> Aids or HIV+ | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Infectious Mono |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Veneral Disease | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Whooping Cough | |

Previous Hospitalization/Serious Illnesses _____

Medications: (Please include non-prescription) & Herbal Supplements

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

Allergies:

Medication	Reaction	Medication	Reaction

Tape Allergy? Yes No **Latex Allergy?** Yes No

Past Surgical History

Please list date, type, hospital and complications.

Patient Social History: (Please circle the appropriate response)

Marital Status	Use of Alcohol	Use of Tobacco	Living Situation	Dominant Hand
Single	Never	Never	With Family	Right
Married	Rarely	Previously, but quit	With Friends	Left
Divorced	Moderate	Currently	Alone	
Widowed	Daily	Other		
Separated		Packs per day _____		

Occupation _____ **Employer's Name and Phone Number** _____

Family Medical History:

Age	Conditions or Diseases	If Deceased, Cause of Death
Father _____	_____	_____
Mother _____	_____	_____
Siblings _____	_____	_____
_____	_____	_____

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms			Integumentary (Skin/Breast)			Ears/Nose/Mouth/Throat		
Bad general health lately	Y	N	Rash or itching	Y	N	Hearing loss or ringing	Y	N
Recent weight change	Y	N	Changes in skin color	Y	N	Earaches or drainage	Y	N
Fever	Y	N	Varicose veins	Y	N	Chronic sinus pain	Y	N
Fatigue	Y	N	Breast pain	Y	N	Nose bleeds	Y	N
Headaches	Y	N	Breast lump	Y	N	Bleeding gums	Y	N
Loss of appetite	Y	N						
Eyes			Respiratory			Cardiovascular		
Eye disease or injury	Y	N	Chronic or frequent coughs	Y	N	Heart trouble	Y	N
Wear glasses/contact lenses	Y	N	Spitting up blood	Y	N	Chest pain or angina pectoris	Y	N
Blurred or double vision	Y	N	Wheezing	Y	N	Palpitations	Y	N
Visual loss/disturbance	Y	N	Shortness of breath	Y	N	Cold extremities	Y	N
			Difficulty breathing	Y	N	Swelling in hands, feet, ankles	Y	N
Gastrointestinal			Genitourinary			Musculoskeletal		
Abdominal Pain	Y	N	Frequent urination	Y	N	Joint pain	Y	N
Nausea or vomiting	Y	N	Burning or painful urination	Y	N	Joint stiffness or swelling	Y	N
Frequent diarrhea	Y	N	Blood in urine	Y	N	Weakness of muscles or joints	Y	N
Constipation	Y	N	Incontinence or dribbling	Y	N	Muscle pain or cramps	Y	N
Rectal bleeding, blood in stool	Y	N	Female – Number of pregnancies			Back pain	Y	N
			Female – Number of deliveries					
Neurological			Psychiatric			Endocrine		
Light headed or dizzy	Y	N	Memory loss or confusion	Y	N	Excessive thirst or urination	Y	N
Numbness or tingling	Y	N	Nervousness	Y	N	Swollen glands in neck	Y	N
Tremors	Y	N	Depression	Y	N	Heat or cold intolerance	Y	N
Paralysis/weakness	Y	N	Insomnia	Y	N	Skin becoming dryer	Y	N
Unsteadiness, difficulty walking	Y	N	Anxiety/Panic attacks	Y	N			
Memory loss	Y	N						
Stroke	Y	N						
Seizures	Y	N						

Hematologic/Lymphatic**Allergic/Immunologic**

Slow to heal after cuts	Y	N	List food / environmental allergies	
Bleeding or bruising tendency	Y	N		
Anemia	Y	N		
Enlarged glands	Y	N		

Pain Questionnaire for Back and Neck Patients

Location _____

Type Burning Aching Numbness Stabbing Pins & Needles

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Signature of Patient or Parent of Minor

Date

Subsequent visit confirmation. The above information is accurate and updated as needed. (Please sign above)

Date