Date _____ Patient ID # _____

PATIENT HEALTH PROFILE

Patient's Name _____ Date of Birth _____
Spouse's Name or Parent's Name (if minor) _____
Reason for today's Visit: _____

Past Medical History:
Past Surgeries & approximate date _____
Past Hospitalization & approximate date _____
Major Medical Problems _____

Immunizations: Tetanus (Last given) _____ **If over age 50:** Last Colonoscopy _____
Pneumonia Shot _____ **MALES:** Last PSA Test _____
Shingles Vaccine_____

Social History:
Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Life Partner _____ Significant Other _____
Do you have children? If so, Please list: Birth year, Sex, any Health Problems.
_____
_____
Occupation _____ _____ Full Time _____ Part Time _____ Retired _____
Do you Exercise? _____ Amount per wk _____ Type _____
Smoking: Current every day _____ Current some day _____ Amount per day _____ Former/Yr Quit _____ Never _____
Alcohol: Never_____ Occasional _____ Moderately _____ Daily _____ Amount per day/wk _____ If stopped, year _____
Recreational Drugs: Never _____ Yes _____ Type/Frequency _____ ___ Previously, but quit/yr _____

Family History: *Please indicate which family member has the health problem.*
High Blood Pressure _____
High Cholesterol _____
Coronary Heart Disease _____
Diabetes _____
Breast Cancer _____
Colon Cancer _____
Prostate Cancer _____
Alcoholism _____
Mental Illness _____
Father: Alive/Birth yr _____ Passed/yr _____ Medical Problems _____
Mother: Alive/Birth yr _____ Passed/yr _____ Medical Problems _____
Brothers: How many _____ Medical Problems _____
Sisters: How many _____ Medical Problems _____

Other:
Allergies (Medications, food or other): _____
Medications (Name, strength, dose): _____
_____
_____

Please Bring your Medication with you if this is easier

Females Only:

Last Mammogram _____ Normal _____ Abnormal _____ Last PAP _____ Normal _____ Abnormal _____

Age of 1st Menstrual Period _____ Date of Last Period _____ Number of Pregnancies _____

Any Miscarriages _____ Birth control? _____ Type _____ Menopausal _____

Please circle any health conditions you have had or are currently having:

Weight loss/Weight gain
Anxiety
Headaches
Depression
Seizures
Stroke
Tingling Location
Tremors
Memory Loss
Fainting spells/dizziness
Head Injury
Localized weakness/numbness

Hay fever
Allergies
Hoarseness
Double Vision
Eye Problems
Ear infections
Glasses/contacts
Hearing Loss
Frequent nose bleeds
Ringing in ears
Sinus infections
Swollen Glands

Chest pain
Heart Murmurs
Leg cramps while walking
Ankle swelling
Awakening at night short of breath
Cold hands/feet
Heart attacks
Heart Failure
High/low Blood pressure
Irregular heart rate
Palpitations

Varicose veins

Wheezing
Asthma
prolonged cough
cough with exercise
emphysema/COPD
shortness of breath
Pneumonia
Bronchitis

Acne
hives
dry skin
Rashes
Psoriasis
lumps
nail problems
moles-irregular
moles-changed or new
skin tags

Problems urinating
dribbling after urination
painful urination
excessive thirst
involuntary
urination/incontinence
weak flow
Urinating frequently day/night
Kidney disease
frequent bladder infections
painful intercourse
sexually transmitted diseases

diabetes
abnormal body hair
cold intolerance

heat intolerance
increased hair loss
thyroid disease
joint pain/swelling
muscle weakness
morning stiffness

constipation
diarrhea
gallstones
heartburn day/night
problems swallowing
hemorrhoids
blood in stool

MALES ONLY:

hernia
penile discharge
lump on testicle
unable to complete intercourse
problems maintaining or keeping an erection
prostate disease
decreased urine stream

FEMALES ONLY:

hot flashes
D & C
bleeding between cycles
abnormal pap smears
bleeding after intercourse
PMS
heavy bleeding during cycles
discharge from breasts
pelvic inflammatory disease
vaginal discharge
vaginal dryness

Doctors that you Regularly Consult:

Name: _____ Reason _____ Phone _____

Name: _____ Reason _____ Phone _____

Name: _____ Reason _____ Phone _____

Name: _____ Reason _____ Phone _____