Patient Health History

3 4 - 1 4 6 0 9 6

DIRECTION OF FEED

Marking Instructions

- **Use only a number 2 pencil.**
- **Fill in the complete oval as shown below.**

Correct Mark ● Incorrect Marks ◐ ✓ ✗

Name: _____

Date of Appt: _____

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	○	Metal	○
Iodine	○	Seafood	○
Latex	○		

2. Have you been diagnosed with any of the following problems?

	Yes		Yes
Anemia	○	Lupus, Skin	○
Anxiety	○	Lupus, Systemic	○
Arthritis	○	Lymphoma	○
Asthma	○	Mitral Valve Prolapse	○
Blood Clots/DVT	○	Multiple Myeloma	○
Bone Cancer	○	Osteoporosis	○
Breast Cancer	○	Parkinson's	○
COPD	○	Peripheral Vascular Disease	○
Coronary Artery Disease	○	Prostate Cancer	○
Depression	○	Prostate Enlarged	○
Diabetes	○	Reflux	○
Epilepsy	○	Renal Failure	○
Fibromyalgia	○	Rheumatoid Arthritis	○
Heart Disease	○	Sleep Apnea	○
Hepatitis	○	Stomach Ulcer	○
High/Elevated Cholesterol	○	Stroke	○
High Blood Pressure	○	Thyroid Dysfunction	○
HIV	○	Tuberculosis	○
Lung Cancer	○		

3. Indicate family members who have been diagnosed with any of the following:

	Father	Mother	Brother	Sister
Arthritis	○	○	○	○
Bleeding/Clotting Problem	○	○	○	○
Cancer	○	○	○	○
Diabetes	○	○	○	○
Heart Disease	○	○	○	○
High Blood Pressure	○	○	○	○
Leukemia	○	○	○	○
Osteoporosis	○	○	○	○
Problems with Anesthesia	○	○	○	○
Stroke	○	○	○	○

About You:

4. Which is your dominant hand?

○ Right ○ Neither
○ Left

5. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks)

○ None ○ 2-3 per day
○ 1 per day ○ 4 or more

6. Exercise Level (regularly, for 20 minutes or more)

○ No exercise
○ 1-2 times weekly ○ 3+ times weekly

7. Home Living Setting

○ Alone ○ Spouse
○ Children ○ Nursing Home
○ Mother ○ Father
○ Assisted Living ○ Other

8. Do you currently use any of the following?

Tobacco Products

○ None ○ Cigarettes
○ Smokeless Tobacco ○ Cigars

Give the closest amount of cigarettes you smoke in an average day.

○ 1/2 pack ○ 2 packs
○ 1 pack ○ 3 packs
○ 1 1/2 packs

Alcoholic Beverages - *A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.*

○ None
○ Abstainer (less than 12 drinks/yr)
○ Light (1-13 drinks/mo)
○ Moderate (4-14 drinks/wk)
○ Heavy (>2 drinks/day)

Please turn over and complete the rest of your questionnaire.

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LP3533
Rev. 5/12

9. Do you have a dependency or addiction to drugs now or in the past? Yes ○ No ○

10. Do you use recreational drugs? Yes ○ No ○

11. Mark if retired. Yes ○

12. Do you now have or have you recently had any of the following?

Musculoskeletal	Yes	No
Bone deformity	○	○
Limitation of use of joints	○	○
Muscle tenderness	○	○
Pain in back	○	○
Pain in neck	○	○
Painful joints	○	○
Redness overlying joints	○	○
Stiffness in joints	○	○
Stiffness in neck	○	○
Swelling of joints	○	○

Neurologic	Yes	No
Changes in alertness	○	○
Headache	○	○
Loss of bladder control	○	○
Numbness	○	○
Tingling	○	○
Weakness	○	○

Cardiovascular	Yes	No
Blacking out or fainting	○	○
Bluish discoloration of lips or fingernails	○	○
Chest pain	○	○
Heart murmur	○	○
Irregular heartbeats	○	○
Leg cramps when walking	○	○
Swelling of ankles	○	○

Respiratory	Yes	No
Cough	○	○
Shortness of breath	○	○
Wheezing	○	○

Gastrointestinal	Yes	No
Abdominal pain	○	○
Diarrhea	○	○
Heartburn	○	○
Nausea	○	○
Vomiting	○	○

12. Do you now have or have you recently had any of the following? *(continued)*

Constitution	Yes	No
Chills	○	○
Fever	○	○
Generalized aching	○	○

Eyes	Yes	No
Blurred vision	○	○
Double vision	○	○
Loss of vision	○	○

Ears/Throat	Yes	No
Dizziness	○	○
Hearing loss	○	○
Ringing in the ears	○	○
Sore throat	○	○

Allergic/Immunologic	Yes	No
Food intolerances	○	○
Hives	○	○
Reaction to insect bites	○	○
Seasonal rhinitis	○	○

Endocrine	Yes	No
Cold feeling	○	○
Fatigue	○	○
Feel hot when others do not	○	○
Urinating more than usual	○	○

Hematologic	Yes	No
Bleeds excessively after injury	○	○
Bruises easily	○	○
Masses (lumps) in armpit	○	○
Masses (lumps) in groin	○	○
Masses (lumps) in neck	○	○

Integumentary/Skin	Yes	No
Nail changes	○	○
Rash	○	○
Ulcers	○	○

Patient Health History

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.
- Fill in date on the line when MM/YR is present.

Correct Mark ● Incorrect Marks ⊘ ✓ ✗

3 6 - 3 8 2 1 4 7

DIRECTION OF FEED

Name: _____

Date of Appt: _____

1. Race *(Mark Only One)*

American Indian or Alaskan Native	○	Native Hawaiian or Other Pacific Islander	○
Asian	○	Some Other Race	○
Black or African American	○	White	○
Decline to State	○		

2. Ethnicity *(Mark Only One)*

Decline to State	○	Not Hispanic or Latino	○
Hispanic or Latino	○		

3. Preferred Language *(Mark Only One)*

English	○	Spanish	○

4. Preferred method of receiving office reminders *(Mark Only One)*

Opt Out	○	Home Fax	○
Home Phone	○	Work Fax	○
Work Phone	○	Mail	○
Mobile Phone	○	Patient Portal	○
Other Phone	○		

5. Food Allergies or Intolerances

	Yes		Yes
Eggs	○	Yeast – Baker's	○

6. Cancers

	Date Diagnosed	Yes
Bladder		○
Bone		○
Brain		○
Breast		○
Cervical		○
Colon		○
Esophagus		○
Ewing's Sarcoma		○
Hodgkin's Disease		○
Kaposi Sarcoma		○
Kidney		○
Larynx		○
Leukemia		○
Liver		○
Lung		○
Lymphoma		○
Multiple Myeloma		○
Ovarian		○
Pancreas		○
Pheochromocytoma		○
Polycythemia Vera		○
Prostate		○
Rectum		○
Skin – Basal Cell		○

6. Cancers *(continued)*

	Date Diagnosed	Yes
Skin – Malignant Melanoma		○
Skin – Squamous Cell		○
Skin – Unknown Type		○
Stomach		○
Testicular		○
Throat		○
Thyroid		○
Uterine		○

7. Past Health History

	Date Diagnosed	Yes
High Blood Pressure (Hypertension)		○
Pregnant – Pregnancy Has Been Confirmed		○
Encephalopathy		○
Neuralgia		○
Neuritis		○
Paralysis		○
Progressive Neurologic Disorder		○
Radiculitis		○
Intravenous Drug Abuse		○
Autoimmune Disorder		○
HIV Positive (Asymptomatic)		○

8. Past Surgeries

	Procedure Date	Yes
Colectomy – Total		○
Colonoscopy		○
Hysterectomy		○
Mastectomy – Details Unspecified		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Modified Radical		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Radical		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Simple		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○

EXAMPLE TO FILL IN DATES

If you have had paralysis in December of 1990, fill in the oval and write the date as shown below.

Paralysis 12/90 ●

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9. Mark any back injuries you have had:

	Injury Date	Yes
Thoracic injury of the back		○
Lumbar injury of the back		○
Ruptured disc – L1-2		○
Ruptured disc – L2-3		○
Ruptured disc – L3-4		○
Ruptured disc – L4-5		○
Ruptured disc – L5-S1		○
Ruptured disc – S1-2		○
Ruptured disc – Specific location unknown		○
Wound (gun shot) to back		○
Wound (stab wound) to back		○
Vertebral fracture – Lumbar		○
Vertebral fracture – Thoracic		○
Vertebral fracture – Location unspecified		○

10. Immunizations Immunization Date

Diptheria – Tetanus – Pertussis (DTP)

MARK EITHER:		Yes
Completed series	MM-YR	○
OR		
#4 of series	MM-YR	○
#5 of series	MM-YR	○

Haemophilus Influenza Type B Conjugate Vaccine (HIB)

MARK EITHER:		Yes
Had series in past		○
OR		
#2 of series		○
#3 of series		○
Booster		○

Hepatitis A (HAV)

		Yes
#2 of series	MM-YR	○
Booster	MM-YR	○

Hepatitis B Vaccine (HBV)

MARK EITHER:		Yes
Had the series		○
OR		
#3 of series		○
#4 of series		○
Repeat series was administered		○
Booster		○

Influenza Vaccine

		Yes
Never received this vaccine		○
Has received this vaccine		○
Declined vaccine		○

Measles – Mumps – Rubella (MMR)

MARK EITHER:		Yes
Completed the series		○
OR		
First or only MMR vaccination		○
Second MMR vaccination		○

10. Immunizations *(continued)* Immunization Date

Pneumococcal Conjugate Vaccine (PCV)

(Pneumonia vaccine given as a child)		Yes
Booster		○

Pneumococcal Polysaccharide Vaccine (PPV)

(Pneumonia vaccine given as an adult)		Yes
Primary PPV immunization		○
Revaccination		○

Polio – Inactivated Polio Virus (IPV)

MARK EITHER:		Yes
Completed the series		○
OR		
#3 of series		○
#4 of series		○

Rotavirus Vaccine

MARK EITHER:		Yes
Has received 2 or more doses		○
OR		
#2 of series		○
#3 of series		○

Varicella (VZV)

MARK EITHER:		Yes
Has received 1 or more doses		○
OR		
#1 or only immunization		○
#2		○

11. Most Recent Diagnostic/Screening Tests

	Test Date	Yes
Colonoscopy		○
Fecal Occult Blood Testing (FOBT)		○
Sigmoidoscopy – Flexible		○
Pap Smear		○
Mammography		○

12. Current Smoking Status

(Mark one of the following)	Yes
Never smoked	○
Former smoker	○
Current every day smoker	○
Current some day smoker	○

13. Use of tobacco products in the past that are no longer used.

(Mark if applicable) ○

Thank you for completing this pre-assessment