Gulf Coast Medical Center
NCQA Recognized Patient-Centered Medical Home

_____Account Number

Patient Health History Form

Please complete this history form while waiting to see your physician. All information is confidential and is helpful in your treatment.

Patient Name:_____Today's Date:_____

Age:_____ Date of Birth:_____ Date of Last Physical Examination:_____

Symptoms/Problems: Check symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐

MUSCLE/JOINT/BONE

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITOURINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – flashes
- ☐ Other

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN Only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

Have you had a mammogram?_____

WOMEN Only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period:_____

Date of last Pap Smear: _____

Date of last mammogram?_____

Are you pregnant?_____

Number of children:_____

Conditions/Illnesses: Check conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

Medications: List any medications you are currently taking.

_____

_____

_____

Allergies: (Food/Environmental/Drug)

_____

_____

Reaction:

Pharmacy Name:_____**Phone:**_____

Family History: Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following: Disease:	Relationship to You:
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Mental Illness	
					Hereditary Problems	

Hospitalizations/Surgeries/Serious Illnesses/Injuries:

Year	Hospital	Reason for Hospitalization and Outcome

Female:

Year of Birth	Sex of Birth	Complications?

Date of Last Health Physical: _____

Did you have any: Lab:_____X-rays:_____Other:_____

Immunizations:

Last MMR (Measles, Mumps, Rubella): _____

Last Flu: _____ Last Pneumonia: _____

Contraception Method:_____

Menses Start Date:_____

Last Mammogram: _____

Last Breast Exam: _____

Menopause Start Date:_____

Last PAP Smear: _____

Male: Last self-testicular exam _____

History of Sexually Transmitted Diseases?_____

Do you practice safe sex? _____

Diet/Exercise:

Type of Diet: _____

Do you exercise? (Circle one)

No Minimal Moderate

Have you ever had a blood transfusion?

☐ Yes ☐ No

If yes, please give approximate dates:

_____

_____

Health Habits: Check which substances you use and describe how much you use.

	Caffeine	☐ None	☐ 1 or 2	☐ 3-4	☐ 5 or more
	Tobacco	☐ None	☐ 1 pack/wk	☐ 1 pk/day	☐ 2 pks/day
	When did you stop smoking?		How long did you smoke?		
	Drugs	☐ None	☐ Prescription		☐ Recreational
	Alcohol	☐ None	☐ Social	☐ 1-2 day	☐ 3 or more/day

Fall Risk:

Have you fallen any time during the past year? ☐ Yes ☐ No

How many falls?_____When?_____

Injury?_____

Other:

Spiritual or Cultural Preferences?

Healthcare Proxy

Durable Power of Attorney for Healthcare

Advance Directive ☐ Yes ☐ No

Name:_____

Relationship:_____

☐ Patient unable/unwilling to discuss advanced directive

Primary Care Giver

Occupational: Check if your work exposes you to the following

	Stress
	Heavy Lifting
	Repetitive Motion
	Have you ever been exposed to chemicals or radiation? ☐ Yes ☐ No

Occupation:

Contact Phone # of Primary Care Giver

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____Date_____

Reviewed By_____Date_____