PATIENT HEALTH HISTORY FORM

For NEW patients to: William Foutz MD, & Mark Stephens MD

*Returning patients ONLY need to fill out any changes since your last Physical Exam (recent surgeries, current meds, new diagnosis, etc.)

Patient Name: _____ Age: _____

Current Medication(s) / dose:

_____ _____

_____ _____

_____ _____

_____ _____

Vitamins / Supplements:

_____ _____

_____ _____

List and Allergies and Drug reactions:

_____

_____

MAJOR HEALTH CONDITIONS

Please check all health conditions that apply:

□ Arthritis	□ Heartburn	□ Seasonal Allergies	□ Asthma
□ Heart Disease	□ Seizures	□ Blood Clots	□ High Blood Pressure
□ Sleep Apnea	□ Cancer	□ High Cholesterol	□ Stroke
□ COPD	□Kidney Disease / Stones	□ Thyroid	□ Depression
□ Migraines	□ Ulcers	□ Diabetes	□ Osteoporosis

□ Other _____

05.12.20

Surgical History type / date:

_____ _____

_____ _____

_____ _____

WOMEN ONLY

Last menstrual period? _____ Normal? □ Yes / □ No If no: _____

If menopausal, did period cease? □ Yes / □ No Approximate Year _____

Have you ever been pregnant? □ Yes / □ No If yes, how many times? _____

Do you have any children? □ Yes / □ No If yes, how many? _____

Last pap smear? _____ Normal? □ Yes / □ No If no: _____

Last mammogram (if > 40yrs)? _____ Normal? □ Yes / □ No If no: _____

Last bone density (if menopausal)? _____ Normal? □ Yes / □ No If no: _____

Last colonoscopy (if > 50yrs)? _____ Normal? □ Yes / □ No If no: _____

MEN ONLY

OVER THE AGE OF 18

Last PSA? _____ Normal? □ Yes / □ No If no: _____

Last colonoscopy? _____ Normal? □ Yes / □ No If no: _____

HEALTH CARE MAINTENANCE

Have you had the following vaccines?

Tetanus □ Yes / □ No If yes, approximate date/year? _____

Influenza □ Yes / □ No If yes, approximate date/year? _____

Pneumovax (if > 65yrs) □ Yes / □ No Shingles Vaccine (if > 60yrs) □ Yes / □ No

Last eye exam, approximate date or year? _____

Last dental visit, approximate date or year? _____

Last hearing check (if > 65yrs), approximate date or year? _____

SOCIAL HISTORY

Hometown: _____
Education – Mark highest level of school completed: □ High School □ College □ Other: _____
Travel history – please list: _____
Military Service? □ Yes / □ No If yes, please describe _____
Do you currently smoke? □ Yes / □ No If yes, how much? _____
If yes, how many years? _____ Would you like to quit? □ Yes / □ No **OR** □ Need more info.
If no, did you ever smoke? □ Yes / □ No When did you quit? _____
Do you currently drink? □ Yes / □ No If yes, how much? _____
If no, did you ever drink? □ Yes / □ No If yes, how much? _____
Have you ever had any problems with addiction? □ Yes / □ No
What kind of work do you do? _____
How long have you lived in this area? _____
Do you exercise? □ Yes / □ No If yes, what kind and how often? _____
Marital Status? _____
Have you ever been abused physically, verbally, or sexually? □ Yes / □ No
Do you feel threatened in any of your relationships? □ Yes / □ No
Do you have a Living Will? □ Yes / □ No **OR** □ Need more info.
Do you have a Medical Power of Attorney? □ Yes / □ No **OR** □ Need more info.

FAMILY HISTORY – Check or circle all that apply (give details where appropriate)

	Living? (circle)	Age(s)	If deceased: age/cause	Cancer	Diabetes	Heart Disease	Hypertension
Mother	Y / N						
Father	Y / N						
Siblings							
	Y / N						
	Y / N						
	Y / N						
	Y / N						
Children							
	Y / N						
	Y / N						
	Y / N						
	Y / N						

PRE-OP VISITS ONLY – Check or circle all that apply (give details where appropriate)

Previous surgical complications? □ Yes / □ No If yes, please specify? _____

Personal or family history of bleeding disorders? □ Yes / □ No If yes, please specify? _____

Can you walk up a flight of stairs? □ Yes / □ No If no, why not? _____

Please list any additional health concerns you would like to discuss today: