

Health History & Review of Systems

Patient Name:	Date:	Da	ate of Birth:					
What are your preferred pronouns?	□ he/him □ she/	ner 🗆 they/them	other:					
	MEDICAL PROBL	EMS						
Please list any medical problems or concerns you may have.								
	SPECIALISTS							
Please provide the names of any special	Please provide the names of any specialists you have seen, and the name of the facility where you received care.							
	CURRENT MEDICA	TIONS						
Please list all medicat	ions that you take. (pre		escription)					
Medication:		Dose:	Frequency:					
	MEDICATION ALLE							
List any medication reactions you have a Medication:	experienced, such as p Reaction:	enicillin or sulfa. Be s	ure to list new allergies first.					
Wedication.	redetion.							
	CURCIONI IUCT	2 D.V						
SURGICAL HISTORY Please provide a list of all previous surgeries, along with the years they were performed.								
Surgery:	evieus sargeries, along	wantile years they	Year:					



FAMILY HISTORY									
Please circle the	e problem and give	ve the age whe	n the problem begar	n if known.					
ILLNESS	MOTHER	FATHER	SISTER	BROTHER	GRANDPARENT				
Diabetes					<u> </u>				
Breast Cancer	□		□		□				
Prostate Cancer	□	□	□		□				
Colon Cancer					O				
Heart Disease or Heart Attack					<u> </u>				
High Blood Pressure			<u> </u>						
Stroke				<u> </u>					
Alcoholism					<u> </u>				
Osteoporosis (weak bones, hip									
fracture)									
Depression			<u> </u>						
Anxiety									
Bipolar					□				
REPRODUCTIVE HISTORY									
Have you ever been pregnant?	□ Yes	□ No	If yes, how many	times?					
Number of:	Miscarriages:_	•	Abortions:		ren:				
Do you use anything to prevent pregna			□ Yes		□ No				
If yes, what type?									
Please share any additional information important for your provider below:									
	IMMUNIZATIONS								
Are you needing immunizations updated?			□ Yes		□ No				
Which immunizations do you need?									
	DDEV	ENTATIVE CAL	D.F.						
Diagon de composit all		ENTATIVE CA							
Please document all		LOCATION	nd location of the m	RESULTS					
	DATE	LOCATION		RESULTS					
Mammogram									
Pap Smear									
Bone Density (DEXA)									
Abdominal Aneurysm (AAA)									
Eye Exam									
Colonoscopy, FIT and Cologuard									
Hepatitis C Screening									
HIV Screening									
Prostate Cancer Screening(PSA)									



HEALTH HABITS

Please select or note the appropriate answer for each section.

TOBACCO USE

Smoking status/history	□ I smoke everyday □ I smok			some days	□ I am a former smoker					
Cinorally status, motory	□ Passive smoker (live with others who smoke)		rho smoke)	□ I have never smoked						
How many total years have you smoked?	□ < 5	□ 5 - 10	□ 11 - 15	□ 16 - 20	□ 21 - 25	□ > 25				
On average, how many packs of cigarettes have you smoked each day throughout your life?	□ 1/4 pack	□ 1/2 pack	□ 1 pack	□1.5 packs	□ 2 packs	□ 3 or more				
Smokeless tobacco status/history	□ Current user □ Former user			□ Ne	□ Never used					
If you use any tobacco, are you ready to quit?			□ Yes		□ No					
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RECREATIONAL DRUG USE										
Do you use recreational drugs?			□ Yes		□ No					
ALCOHOL USE										
How often do you consume an alcoholic beverage	How often do you consume an alcoholic beverage?		□ Monthly or less	□ 2-4 Times per month	□ 2-3 Times per month	□ 4 or more times per week				
On a typical day, how many alcoholic drinks do you consume?			□ 3 - 4	□ 5 - 6	□ 7 - 9	□ 10 or more				
How often do you consume six or more alcoholic drinks in a single occasion?			□ Less than monthly	□ Monthly	□ 2-3 times per week	□ 4 or more times per week				
Please provide the total number of drinks consumed each week, per by type of alcohol.	Glasses of wine Cans/bottles			of beer	Shots of liquor					
	PHYSICA	AL ACTIVIT	Y							
On average, how many days/week do you engage in moderate to strenuous exercise? (such as a brisk walk) days										
On average, how many minutes do you engage in exercise activity at this level? minutes										
Total minutes per week of physical activity (multiply days by minutes.):				minutes per week						
How many days a week do you perform muscle-strengthening exercises? (such as bodyweight exercises or resistance training)				days per week						
Do you feel it is important to lose weight				t this time?	□ Yes	□ No				
How often do you wear your seatbelt?	□ Al	□ Always □ Sometimes □ Never			Never					