KG Health Partners
Physician Services Group

# Patient Health History Form

Account Number________________

**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 heartbeat
- ☐ 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)

________________________________________

________________________________________

Rection:

**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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Date of Last Health Physical: ______________________________

Did you have any: Lab:__________X-rays:____________Other:____________

**Immunizations:**

Last MMR (Measles, Mumps, Rubella): ______________________________

Last Flu: ____________________ Last Pneumonia: ____________________

## Female:

| Year of Birth | Sex of Birth | Complications? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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 ____________________