AULTMAN ORRVILLE CARROLLTON HEALTH CENTER
NEW PATIENT HEALTH HISTORY FORM

APPOINTMENT DATE_____ APPOINTMENT TIME_____

PROVIDER_____

Patient Name:		Patient DOB:		Date			**Page 1**

Relationship Status:	**□ Married □ Single □ Separated □ Divorced □ Widowed □ Life Partner**
Children:	**□ Yes □ No**
Education:	**□ Some High School □ High School Graduate □ Some College □ College Grad**

1. How often do you have somebody help you read hospital materials? ☐ Often ☐ Rarely ☐ Never

1. How confident are you filling out medical forms by yourself? ☐Extremely Comfortable ☐ Comfortable ☐ Uncomfortable

2. How often do you have problems learning about your medical condition because of difficulty understanding written information? ☐ Often ☐ Rarely ☐ Never

HEALTH PARTNERS	Names of your other physicians?	What is their specialty?

ALLERGIES/REACTION: (Please list food, drug and latex allergies)

1.	Reaction:	
2.	Reaction:	
3.	Reaction:	

Additional allergies:

MEDICATIONS (Prescriptions, over the counter, herbal preparations and supplements)

Medication Name	Dosage	Frequency	Route (oral/IM)	Reason	Ordering Physician
Failed Medications:					

PREVIOUS HOSPITALIZATIONS AND SURGERIES

Reason for hospitalization	Date	Name of Surgeon

Tobacco Use:	□ Never Smoked or chewed tobacco □ Former Smoker (How long ago? ____ yrs) □Current Cigarette Smoker □ Current Cigar Smoker □ Current Chewing Tobacco How much per day? __ How many years? _
Alcohol Use:	□ Never □ Occasionally □ Moderate □ Heavy Amount per day/week/month
Caffeine Use:	□ Never □ Number of Cups/Can Daily? _____ □ Coffee □ Tea □ Carbonated Beverages □ Other_____
Drug Use:	□ Never □ Past Use □ Currently using drugs? What drug(s)? _____
Tattoos/Piercings	□ Single □ Multiple Locations:

PERSONAL & FAMILY MEDICAL HISTORY (Check all that apply)

			List Cause of Death
Is your mother alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	
Is your father alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	
Is your maternal grandmother alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	
Is your maternal grandfather alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	
Is your paternal grandmother alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	
Is your paternal grandfather alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	

		Is there a family history? If yes, please check who								
	Self	Mom	Dad	Brother	Sister	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Child
Alcoholism										
Anemia										
Arthritis										
Asthma										
Barium X-rays										
Bladder infections/stones										
Blood Clots										
Broken Bones. Where:										
Bronchitis										
Cancer: Type:										
Addt'l Info for Cancer:										
Concussion										
Diabetes: Type:										
Drug Abuse										
Depression										
Epilepsy/Seizures										
Gallbladder disease										
Glaucoma										
Hair Loss										

Head Injury										
Heart catheterization										
Heart Disease										
Addt'l Info for Heart Disease:										
	Self	Mom	Dad	Brother	Sister	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Child
Hepatitis										
High Blood Pressure										
High Cholesterol										
HIV/Immune DX										
Kidney infections/stones										
Kidney disease										
Liver Disease										
Hepatitis										
Lung Disease										
Mental illness										
Migraines										
Mononucleosis										
Moodiness										
Osteoarthritis										
Osteoporosis										
Pain: Location:										
Phlebitis (inflammation of vein)										
Pneumonia										
Rheumatic Arthritis										
Rheumatic Fever										
Seizures										
Sprains										
Stroke										
Suicide Attempt										
Thyroid Disease										
Tuberculosis										
Ulcer in GI Tract										
Venereal Disease										
Whiplash										

REVIEW OF SYSTEMS

Y	N	?	GENERAL	
			Weight gain in the last year	
			Weight loss in the last year	
			Fevers, chills or sweats	
			Change in appetite	
			Extreme fatigue	
Y	N	?	SKIN	
			Rashes	
			Ulcers	
			Dryness	
			Scaling	
			Sores	
			Slow healing	
			Abnormal hair loss	
			Unusual moles	
Y	N	?	HEAD	
			Headaches	
			Dizziness	
			Vertigo	
Y	N	?	EYES	
			Do you wear glasses/contacts	
			Blurred/Double vision	
			Blind spots	
			Loss of peripheral vision	
			Pain	
			Itching	
			Redness, drainage or crusting	
			Injuries	
Y	N	?	EARS	
			Changes in hearing	
			Ringing in ears	
			Pain	
			Drainage	
			History of frequent infections	
			Injuries	
Y	N	?	NOSE	
			Nosebleed	
			Sinus drainage	
			Runny Nose	
			Post Nasal Drip	
			Stuffy Nose	
			Sneezing/Allergies	
Y	N	?	THROAT	
			Pain or sore	
			Hoarseness	
			Difficulty swallowing	

Y	N	?	NECK	
			Thyroid problems	
			Goiter	
			Swollen glands	
Y	N	?	MOUTH	
			Sores on lips	
			Dental problems	
			False teeth	
			Problems with false teeth	
			Bleeding of gums	
Y	N	?	HEMATOLOGIC	
			Anemia	
			Sickle cell anemia	
			Easy bruising from skin	
			Problems with excessive bleeding	
Y	N	?	RESPIRATORY	
			Exposure to someone with TB	
			Wheezing	
			Shortness of breath	
			Chronic cough	
			Phlegm or sputum	
			Coughing up blood	
Y	N	?	CARDIOVASCULAR	
			Chest pain/heaviness	
			Palpitations/Abnl heart rate	
			High blood pressure	
			Heart murmur	
			Shortness of breath with exertion	
			Waking up with shortness of breath	
			Trouble breathing lying flat	
			Varicose veins	
			Leg pain with walking	
			Leg cramps	
			Swelling of legs or ankles	
Y	N	?	GASTROINTESTINAL	
			Ulcers	
			Frequent nausea	
			Frequent vomiting	
			Diarrhea or loose stools	
			Constipation	
			Hemorrhoids	
			Rectal bleeding	
			Black stools	
			Alcohol use	
			Abdominal pains or cramps	

REVIEW OF SYSTEMS

Y	N	?	GENITOURINARY	
			Burning on urination	
			Trouble starting urine flow	
			Trouble stopping urine flow	
			Loss of control of urine	
			Frequency of urination	
			Getting up at night to urinate	
			Blood in urine	
			Stones in kidney or bladder	
Y	N	?	ORTHOPEDIC	
			Muscle aches	
			Muscle spasms	
			Severe sprains	
			Joint pain, stiffness or swelling	
			Back problems	
Y	N	?	NEUROLOGIC	
			Numbness	
			Weakness or paralysis	
			Passing out or loss of consciousness	
			Tingling	
			Worsening memory	
			Difficulty concentration	
Y	N	?	ENDOCRINE	
			Excessive thirst	
			Excessive urination	
			Decreased sex drive	
			Thyroid problems	
			Sensitive to heat or cold	
			Other hormone problems	
Y	N	?	GYNECOLOGIC	
			Age started period	
			Change in life (menopause)	
			Irregular periods	
			Pregnancies	
			Deliveries	
			Miscarriages	
			Discharge	
			Spotting	
			Breast discharge or milk	
			Irregular vaginal bleeding	
			Vaginal itching	
Y	N	?	OTHER	
			Moving legs a lot at night	
			Genital Warts	
			Genital Herpes	
			Sexually Transmitted Disease	
			Multiple sexual partners	
Y	N	?	MEN ONLY	
			Difficulty gaining erections	
			Difficulty maintain erections	
			Testicular lumps	
			Do you perform testicular self-exams?	
Y	N	?	WOMEN ONLY	
			Breast pain or lumps	

RECOMMENDED SCREENING/PREVENTIVE SERVICES	
	DATE
Last Physical Examination	
Last Dental Visit	
Colonoscopy	
EGD (Scope of esophagus, stomach, small bowel	
Pap Smear	
Mammogram	
Tetanus Booster	
Zostavax (shingles vaccine/chicken pox)	
Pneumovax	
Prevnar (Pneumonia Booster)	
Influenza Vaccine	
Cholesterol Screening	
Bone Density (Females)	
PSA (Prostate Specific Antigen (Males)	
Eye Exam	

	Date	Provider Name
Last Retinal Eye Exam		
Last Foot Exam by Podiatrist		

HEARING ASSESSMENT (If you are 18 to 64 years old, the following questions will help you determine if you need to have your hearing evaluated by a health professional)		
Do you currently have hearing aids (If yes, skip this section)	□ Yes	□ No
Does a hearing problem cause you to feel embarrassed when you meet new people?	□ Yes	□ No
Do you have difficulty hearing or understanding co-workers, clients, or customers?	□ Yes	□ No
Do you fell slowed down by a hearing problem?	□ Yes	□ No
Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	□ Yes	□ No
Does a hearing problem cause you difficulty in the movies or in the theater?	□ Yes	□ No
Does a hearing problem cause you to have arguments with family members?	□ Yes	□ No
Does a hearing problem cause you difficulty? when listening to TV or radio?	□ Yes	□ No
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	□ Yes	□ No
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	□ Yes	□ No
If you answered "Yes" to three or more of these questions, you may want to see an audiologist (a hearing specialist) for a hearing evaluation. Ask us for a referral.		

Physician Review: _____ Date: _____