PHYSICIANS' CLINIC
of Iowa, P.C.

HEALTH HISTORY FORM

Today's Date _____ First Name _____ Last Name _____

Nickname _____ Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female Pregnant? ☐ Yes ☐ No

Height (feet/inches) _____ Weight (pounds) _____ I request a chaperone during today's visit: ☐ Yes ☐ No

Family Physician _____ Referring Physician _____

Hospital Preference: ☐ Mercy Medical Center (Cedar Rapids) ☐ St. Luke's Hospital ☐ Surgery Center Cedar Rapids

Reason for today's appointment (symptoms, onset, duration) _____

_____

Do you have an advanced directive? ☐ Yes ☐ No If yes, who is your surrogate decision maker? _____

Recent tests or x-rays (when and where) _____

_____

MEDICATIONS: List all medications you have been taking. Please include over the counter and any supplements; list dosages and frequency.

Name of Medication (☐ See attached list for additional medications.)	Dose	Frequency

ALLERGIES: Please list any allergies.

Drug	Describe Reaction	Other *(seasonal, food, etc.)*	Describe Reaction

Do you have sensitivity to Latex? ☐ Yes ☐ No Describe Reaction: _____

Please check any previous surgeries you have had:

☐ Appendix ☐ Colon ☐ Heart ☐ Kidney ☐ Neck ☐ Throat ☐ Vasectomy
☐ Bladder ☐ Ear ☐ Hernia Repair ☐ Lung ☐ Prostate ☐ Tonsillectomy
☐ Cataract ☐ Gallbladder ☐ Joint Replacement ☐ Nasal/Sinus ☐ Testicle ☐ Urinary Stone
☐ Other (please describe) _____

PAST HOSPITALIZATION, SURGERIES, OR INJURIES:

Hospitalization for:	When:	Where:

PAST HEALTH HISTORY: *(Check all that apply)*

☐ Arthritis ☐ Diabetes Mellitus ☐ Kidney Disease ☐ Received Blood in Past ☐ Tuberculosis
☐ Blood Clots ☐ Eye Conditions ☐ Liver Disease/Hepatitis ☐ Stomach/Intestinal Problems ☐ Ulcers
☐ Cancer/Type _____ ☐ Heart Disease ☐ Lung Disease/Asthma
☐ Depression/Psychiatric Disorders ☐ High Blood Pressure ☐ MRSA/VRE ☐ Stroke
☐ High Cholesterol or Lipids ☐ Obstructive Sleep Apnea ☐ Thyroid Disorder

Other Medical Conditions (please list): _____

SOCIAL HISTORY:

Occupation: _____
☐ Retired
☐ Currently on Disability
☐ Working Full Time
☐ Working Part Time
☐ Unemployed
☐ Student

Marital Status:
☐ Single
☐ Currently Married/Partnered
☐ Divorced
☐ Widowed
Spouse/Partner Name: _____

Diet & Caffeine Use:
Do you use caffeine? ☐ Yes ☐ No
How much? _____
Daily fruit/vegetable intake? _____

Please continue to the back side →

SOCIAL HISTORY ***(continued)*****:**

Exercise Habits:
☐ Exercise Regularly
Type/frequency? _____
☐ Exercise Occasionally
☐ Exercise Rarely
☐ Do Not Exercise

Alcohol/Drug Use:
Do you use alcohol? ☐ Yes ☐ No
How many drinks per week? _____
Have you used drugs for non-medicinal purposes? ☐ Yes ☐ No

Tobacco Use:
☐ Current Smoker
How much/how long? _____
☐ Chewing Tobacco
☐ Former Smoker/Date Quit _____
☐ Never Smoked

FAMILY HISTORY: Has any member of your family (not to include spouse or in-laws) ever had the following conditions. If yes, indicate family member.

		Family Member			Family Member
☐ Yes ☐ No	Arthritis		☐ Yes ☐ No	High Blood Pressure	
☐ Yes ☐ No	Cancer (include type)		☐ Yes ☐ No	Kidney Disease	
☐ Yes ☐ No	Diabetes Mellitus		☐ Yes ☐ No	Lung Disease (COPD)	
☐ Yes ☐ No	Eye Conditions		☐ Yes ☐ No	Stroke	
☐ Yes ☐ No	Heart Disease		☐ Yes ☐ No	Stomach/Intestinal Problems	
☐ Yes ☐ No	High Cholesterol/Lipids		☐ Yes ☐ No	Ulcers	
☐ Yes ☐ No	Liver Disease/Hepatitis				

☐ Unable to obtain family history due to adoption or other circumstances.

Please share the following information regarding your immediate family (i.e. father, mother, children, brothers, and sisters.)

Family Member	Alive/Year Born	Deceased/Age at Death	Cause of Death
Father			
Mother			

REVIEW OF SYSTEMS: Please check all symptoms you have experienced in the last MONTH.

Constitutional/General
☐ Fever
☐ Chills
☐ Heavy Sweating/Night Sweats
☐ Loss of Appetite
☐ Sleep Disturbances
☐ Unexplained Weight Loss/Gain
☐ Other: _____

Eyes
☐ Blurry Vision
☐ Double Vision
☐ Wear Glasses
☐ Other: _____

Ear/Nose/Throat
☐ Sore Throat
☐ Mouth Sores
☐ Nasal Congestion/Sinus Issues
☐ Hearing Loss
☐ Other: _____

Respiratory
☐ Cough
☐ COPD
☐ Wheezing
☐ Recurrent Upper Respiratory Infections
☐ Shortness of Breath
☐ Other: _____

Cardiovascular
☐ Chest Pain or Discomfort
☐ Swelling of Feet, Ankles or Legs
☐ Irregular Heart Beat
☐ Heart Attack
☐ Heart Failure
☐ Palpitations
☐ Varicose Veins
☐ Other: _____

Gastrointestinal
☐ Abdominal Pain
☐ Nausea/Vomiting
☐ Indigestion or Heartburn
☐ Blood in Stools
☐ Change in Bowel Habits
☐ Rectal Bleeding
☐ Diarrhea
☐ Constipation
☐ Swallowing Difficulties
☐ Other: _____

Psychological
☐ Depression
☐ Anxiety
☐ Other: _____

Genitourinary
☐ Painful Urination
☐ Urinary Frequency
☐ Loss of Urinary Control (PQRS 48)
☐ Enlarged Prostate
☐ Difficulty Urinating
☐ Other: _____

Skin
☐ Skin Rash
☐ Itching
☐ Discoloration of the Skin
☐ Lumps or Masses
☐ Other: _____

Musculoskeletal
☐ Joint Pain
☐ Joint Swelling
☐ Back Pain
☐ Limitation of Motion
☐ Neck Pain
☐ Pain with Walking
☐ Other: _____

Endocrine
☐ Excessive Thirst or Fluid Intake
☐ Temperature Intolerance
☐ Feeling Tired (Fatigue)
☐ Hot Flashes
☐ Other: _____

Hematologic/Lymphatic
☐ Swollen Glands
☐ Blood Clotting Problem
☐ Easy Bruising
☐ Bleeding Tendencies
☐ Other: _____

Neurological
☐ Tremors
☐ Dizzy Spells
☐ Numbness or Tingling
☐ Headache
☐ Unsteady Gait
☐ Feeling Weak
☐ Convulsions/Seizure
☐ Other: _____

This Space is Intentionally Blank for Additional Comments:

Patient/Parent Signature: _____

Date: _____

Provider Signature: _____

Date: _____