HARTWIG HEALTH

HEALTH HISTORY

Patient's Name _____ Date of Birth _____ Today's Date _____

Please Answer all questions by circling Yes (Y) or No (N) *All responses are kept confidential*

Do you have any of the following:

Anemia	Yes No	Anxiety	Yes No	Arthritis	Yes No	Asthma	Yes No
BPH	Yes No	Back problem	Yes No	Breast Ca	Yes No	CAD	Yes No
CHF	Yes No	COPD	Yes No	Cancer	Yes No	High lipids	Yes No
Dementia	Yes No	Depression	Yes No	Dermatitis	Yes No	Diabetes	Yes No
Epilepsy	Yes No	GERD	Yes No	Glaucoma	Yes No	Gout	Yes No
HIV	Yes No	Headache	Yes No	Hepatitis	Yes No	Hypertension	Yes No
MI	Yes No	Migraine	Yes No	Pneumonia	Yes No	Kidney stone	Yes No
Stroke	Yes No	TB	Yes No	Thyroid Dz	Yes No	Ulcer (GI)	Yes No

Other medical issues:_____

Infection Hx:

Do you live with someone with TB or exposed to TB
Yes No

Patient or partner with history of genital herpes
Yes No

History of Hepatitis B or C?
Yes No

History of STD (gonorrhea/chlamydia), HPV, HIV or syphilis?
Yes No

FEMALES:

LMP: _____ (if menopausal, final LMP)
Menses normal: Yes No If so, how frequent?
Every _____ days
Menarche (age of first menses): _____

Tobacco use: Yes No
If yes: (circle) Cigarettes Cigars Pipe Chewing Tobacco Last use: _____ Daily use: _____ x _____ yrs

Alcohol use: Yes No
If yes: (circle) Beer Wine Hard liquor Last use: _____

Surgical history:

AAA repair	Yes No	Aortic aneur	Yes No	Appendectomy	Yes No	Breast aug	Yes No
Breast reduced	Yes No	CABG	Yes No	Carotid surgery	Yes No	Cataract	Yes No
C-section	Yes No	Gallbladder	Yes No	Colectomy	Yes No	Duodenal ulcer	Yes No
Lithotripsy	Yes No	Ectopic preg	Yes No	Fracture	Yes No	Hip fracture	Yes No
Gastric band	Yes No	Heart valve	Yes No	Abd hernia	Yes No	Mastectomy	Yes No
Hip surgery	Yes No	Hysterectomy	Yes No	Gastric bypass	Yes No	Pacemaker	Yes No
Knee surgery	Yes No	LS spine surg	Yes No	Lasik	Yes No	Shoulder scope	Yes No
Ovary surgery	Yes No	PTCA	Yes No	PVD procedure	Yes No	TURP	Yes No
Prior surgeries	Yes No	Prostate biopsy	Yes No	Prostatectomy	Yes No	Vasectomy	Yes No
Shoulder surg	Yes No	Sinus surgery	Yes No	Splenectomy	Yes No	Other:_____	
Thyroidectomy	Yes No	Tonsillectomy	Yes No	Tubal ligation	Yes No	Other:_____	

Review of systems: Have you had any of the following in the last 2 weeks? (circle)

<u>CONSTITUTIONAL:</u>
Chills
Fever
Weight loss
Decline in health
Weakness
Fatigue
Weight gain

<u>HEENT:</u>
Dizziness
Headaches
Fainting
Pain
Head injury
Sweats

<u>EYES:</u>
Blurred vision
Double vision
Eyeglass use
Pain with light
Unusual sensation
Cataracts
Excessive tearing
Glaucoma
Recent injury
Vision loss
Eye discharge
Eye pain
Eye infection
Eye redness

<u>NOSE:</u>
Nasal discharge
Nasal infection
Sinus infection

Frequent colds
Nasal obstruction
Hay fever
Nosebleeds

MOUTH:
Bleeding gums
Postnasal drip
Change in dentition
Tongue burning
Hoarseness
Voice changes

EARS:
Ear discharge
Hearing loss
Ringing in ears
Ear infections
Hearing aid
Ear pain

THROAT:
Sore throat
Tonsils enlarged
Lumps in neck
Neck pain

RESPIRATORY:
Asthma
Bronchitis
Pleurisy
Shortness of breath
Cough
Coughing up blood
+ TB test
Sputum
Wheezing
Hx TB

CARDIOVASCULAR:
Chest pain
Cool extremities
Heart murmur
Hx MI
Rheumatic fever
Leg/foot ulcers
Palpitations
Leg pain w/ walking
Exertional chest pain
Leg swelling
Varicose veins
Hair loss on legs
High blood pressure
Short breath w/ lying
Thrombophlebitis

GASTROINTESTINAL
Abd pain
Heartburn
Rectal bleeding
Black tarry stools
Change in stool
Excessive hunger
Hemorrhoids
Laxative use
Swallowing problem
Constipation
Jaundice
Hepatitis
Nausea
Vomiting
Diarrhea
Liver disease
Decreased appetite
Gallbladder disease
Rectal pain
Vomiting blood

MUSCULOSKELETAL:
Arthritis
Back pain
Muscle cramps
Joint pain
Joint deformities
Muscle stiffness
Muscle weakness
Gout
Paralysis

ENDOCRINE:
Depression
Suicidal ideation
Homicidal ideation
Memory loss
Behavioral change
Excessive stress
Mood changes
Disorientation
Hallucinations
Nervousness

SKIN:
Eczema
Bruise easily
Hives
Nail changes
Skin changes
Itching
Dry skin
Mole changes
Rash

NEUROLOGICAL:
Loss of conscious
Tingling
Blackouts
Memory loss
Speech disorders
Tremors
Burning
Numbness
Hx stroke
Unsteady gait
Cold intolerance
Goiter
Weight gain
Excessive urination
Heat intolerance
Weight loss
Fatigue
Increased thirst

HEMATOLOGIC/LYMPH:
Anemia
Easy bruising
Swollen glands
Bleeds easily
Hx blood clots

ALLERGIC/IMMUNE:
Itchy eyes
Runny nose
Sneezing
Hives
Recurrent infections

URINARY:
Nighttime urination
Burning w/ urination
Hx kidney stones
Difficulty starting flow
Urinary frequency
Urinary urgency
Blood in urine
Urinary incontinence
Urinary retention

FEMALE:
Breast discharge
Breast tenderness
Vaginal discharge
Pain with intercourse

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible and that I will have the opportunity to discuss my Health History with my doctor during this appointment.

Date	Signature of Person Completing Health History	Doctor's Initials