

Michael A. Vasquez, M.D., F.A.C.S., R.V.T.
Glenn Buczkowski, RPA-C
Esther M. Sprehe, ANP

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name _____ Birthdate _____ Date _____

Reason for Visit: _____

Location: _____ **Duration:** _____
(WHERE IS THE PAIN/PROBLEM AREA?) (HOW LONG HAVE YOU HAD THIS PROBLEM / ONSET?)

Severity: _____ **Modifying Factors:** _____
(How SEVERE is the pain/problem on a scale from 1-5, 5 being the most severe) (What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank is you are uncertain)

Pneumonia no yes	Tuberculosis no yes	Low Blood Pressure no yes
Rheumatic Fever no yes	Diabetes no yes	Hemorrhoids no yes
Heart Disease no yes	Polio no yes	Asthma no yes
Arthritis no yes	Glaucoma no yes	Hives / Eczema no yes
Anemia no yes	Hernia no yes	AIDS / HIV + no yes
Bladder Infections no yes	Back Trouble no yes	Infectious Mono no yes
Epilepsy no yes	Blood / Plasma Transfusion .. no yes	Bronchitis no yes
Migraine Headaches no yes	High Blood Pressure no yes	Mitral Valve Prolapse no yes
Stroke no yes	Hepatitis _____ no yes	Ulcer no yes
Kidney Disease no yes	Thyroid Disease no yes	Bleeding Tendency no yes
Cancer no yes	Any Other disease _____	

Previous Hospitalizations / Surgeries/ Serious Illnesses	When?	Hospital/ City, State
_____	_____	_____
_____	_____	_____

MEDICATIONS: (Including nonprescription)

Patient Social History:

Martial Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
 Use of Alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
 Use of Tobacco: Never: _____ Previously, but quit: _____ Current packs/ day: _____
 Use of Drugs: Never: _____ Type / Frequency: _____

Family Medical History:

Age	Diseases	If Deceased, Cause of Death
Father _____	_____	_____
Mother _____	_____	_____
Sibling's _____	_____	_____
_____	_____	_____

PATIENT'S: HEIGHT _____ WEIGHT _____ # OF PREGNANCIES _____
(FEMALE'S)

ANY KNOWN ALLERGIES TO MEDICINES OR FOODS: _____

REVIEW OF SYSTEMS: Please Indicate any personal medical history below:

General Health:

Fever no yes
 Chills no yes
 Fatigue no yes

Eyes:

Eye disease or injury no yes
 Blurred or double vision no yes

Ears/Nose/Mouth/Throat:

Hearing loss or ringing no yes
 Earaches or drainage no yes
 Nose bleeds no yes
 Sore throat or voice change no yes
 Swollen glands in neck no yes

Cardiac:

Heart trouble no yes
 Chest pain or angina pectoris no yes
 Palpitation no yes
 Shortness of breathe when
 walking or lying flat no yes

Respiratory:

Chronic or frequent coughs no yes
 Spitting up blood no yes
 Shortness of breathe no yes
 Wheezing no yes

Neurological:

Frequent / recurring headaches ... no yes
 Light headed / dizzy..... no yes
 Convulsions / seizures no yes
 Numbness / tingling sensations ... no yes
 Paralysis no yes
 Head injury no yes

Vascular:

Varicose veins no yes
 Restless legs no yes
 Leg swelling no yes
 Leg Aching no yes
 Leg Fatigue no yes
 Leg Throbbing no yes

Gastrointestinal:

Loss of appetite no yes
 Change in bowel movement no yes
 Nausea / vomiting no yes
 Frequent diarrhea no yes
 Constipation no yes
 Rectal bleeding/ bloody stool no yes
 Abdominal pain no yes

Genitourinary:

Frequent Urination no yes
 Burning / painful urination no yes
 Blood in urine no yes
 Incontinence / dribbling no yes
 Kidney stones no yes

Musculoskeletal:

Weakness of muscles/ joints no yes
 Back pain no yes
 Cold Extremities no yes
 Difficulty walking no yes

Integumentary (skin, breast):

Rash/ Itching/ Burning no yes
 Change in skin color no yes
 Breast pain no yes
 Breast Lump no yes
 Breast discharge no yes
 Leg ulcer no yes

Hematologic / Lymphatic:

Slow to heal after cuts no yes
 Bleeding / bruising tendency no yes
 Anemia no yes
 Phlebitis no yes
 Blood clots no yes

Psychiatric:

Memory loss / Confusion no yes
 Nervousness no yes
 Depression no yes

Endocrine:

Glandular / Hormone problem ... no yes
 Heat / Cold Intolerance no yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

 Signature of Patient, Parent, or Guardian

 Date

 Signature of Doctor

 Date