Fountain Clinic Health History
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Name: _____ DOB: _____ Date: _____

What is your main reason for coming in today? _____

_____

Past medical history: please check if you have had any of the following illnesses/conditions:

Eyes/ears/nose/throat
____Glaucoma
____Vision loss
____Cataracts
____Hearing loss
____Meniere's disease
____Nasal allergies
____Dentures/broken teeth
____Other_____

Nervous System
____Migraine headaches
____Stroke
____Parkinson's
____Multiple Sclerosis
____Head injury
____Seizures/epilepsy
____Depression
____Anxiety
____Bipolar disorder
____Other_____

Heart
____High blood pressure
____Heart failure
____Heart attack
____High cholesterol
____Heart murmur
____Pacemaker or defibrillator
____Atrial fibrillation
____Other_____

Kidney/bladder
____Kidney disease
____Kidney stones
____Blood in urine
____Prostate enlarged (men)
____Other_____

Lungs
____Emphysema/COPD
____Asthma
____Tuberculosis
____Sleep apnea
____Other_____

Skin/nails
____Acne
____Psoriasis
____Eczema
____Skin or nail cancer
____Boils or MRSA
____Other_____

Musculoskeletal
____Rheumatoid Arthritis
____Osteoarthritis
____Lupus
____Gout
____Osteoporosis (bone loss)
____Hernia
____Other_____

Stomach/bowel
____Gall bladder disease
____Cirrhosis (liver)
____Fatty liver disease
____Heartburn/reflux
____Stomach ulcer
____Irritable bowel
____Ulcerative colitis
____Diverticulitis
____Colostomy
____Hemorrhoids
____Other_____

Vascular/Blood
____Anemia
____Blood clots
____Sickle cell anemia
____Clotting disorder
____Other _____

Systemic/infections
____Type 1 diabetes
____Type 2 diabetes
____Hypothyroid
____Hyperthyroid
____Goiter
____Grave's disease
____Hepatitis
____HIV/AIDS
____Cancer _____
____Chicken pox
____Mono
____Scarlet fever
____Other _____

Fountain Clinic Health History
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Name: _____ DOB: _____ Date: _____

Medication allergies or sensitivities:_____

_____

Past Surgical History: Please list any surgeries you have ever had, and approximate date or age:

_____

_____

_____

Men only:
Do you have:
_____ prostate trouble _____ up at night to urinate _____ change in urine stream

____ other male problems? _____

Sexually active? _____yes _____no Partners are : _____women _____men

Women only:
Do you have periods? ____Yes ____No

If no, have periods stopped because of: _____surgery ____menopause ____ablation _____ Other

If currently having periods, are they: _____light ____medium _____ heavy?

Are periods _____regular (every 28-35 days) Or _____ irregular?

Last Pap test:_____ Last mammogram: _____

Any abnormal Pap tests? _____ Any abnormal mammograms? _____

Number of pregnancies: _____ number of births _____ miscarriages _____ Abortions _____

Sexually active? _____yes _____no Partners are : _____men _____women

Fountain Clinic Patient Health History

(Please Print)

Name:_____ **DOB:**_____ **Date:**_____

Family History Please Check All that Apply	Father	Mother	Siblings	Children
Heart disease/heart surgery				
High blood pressure				
Stroke				
Cancer (what kind)				
Diabetes				
Glaucoma				
Epilepsy				
Bleeding disorder				
Kidney disease				
Thyroid disease				
Mental Illness				
Parkinson's disease				
Alzheimer disease				

Other Illnesses in family:_____

If parents or siblings have died, list age and cause of death:_____

Social History

Do you smoke? _____ How much?_____ How many years? _____ Have you quit smoking?_____

Do you drink alcohol?_____ How much/how often? _____ Any heavy alcohol use? _____

Have you used street drugs? _____ What kind? _____ How often?_____

Do you use chewing tobacco?_____ **How much?**_____ **How often?** _____

Have you ever been treated for alcohol or substance abuse?_____ **When?**_____

Do you drink caffeinated drinks_____ **How much?**_____ What kind?_____

Exercise: What Kind?_____ **How Long:**_____ **Days per week:**_____

Yes or No

_____ ***Do you have enough food?**

_____ ***Do you have a place to live?**

_____**Do you eat a special diet?**

_____ **Are you tense or fearful?**

_____**Do you wear seat belts?**

_____**Are you sad or depressed?**

_____ **Do you have smoke detectors in your home?**

_____**Do you feel like "ending it all"?**

_____ **Do you practice safe sex?**

_____ **Is your home tobacco and smoke free?**

_____*** Do you feel safe?**

_____ **Have you had a loss of interest or pleasure in all, or any activities most of the day nearly every day?**

What is your occupation or hobbies:_____

Marital Status: M S D W Partnered

Reviewed By: _____ **Date:**_____