



# WESTERN WISCONSIN MEDICAL ASSOCIATES

## PATIENT HEALTH HISTORY

DATE COMPLETED

NAME	AGE	DOB
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OCCUPATION	SIGNIFICANT OTHER
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LIST ALL SPECIALIST AND PROVIDERS OF HEALTH CARE OUTSIDE OF OUR CLINIC (I.E. CARDIOLOGIST, NEUROLOGIST, UROLOGIST, PHARMACY, EYE DOCTOR, DENTIST, DIABETIC SUPPLIER ETC.)

I currently have Advanced Directives on file:  Yes  No

I would like information about Advanced Directives:  Yes  No

Please indicate if you have had any of the following in the past 3 months:

### SYSTEM REVIEW:

<b>General</b>	<b>YES</b>	<b>NO</b>	<b>Cardiovascular</b>	<b>YES</b>	<b>NO</b>	<b>Hematologic</b>	<b>YES</b>	<b>NO</b>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Fluttering	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Lying Flat	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prior Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Swelling In Legs	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>
			Loss Of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>			
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrine</b>	<b>YES</b>	<b>NO</b>
<b>Eyes</b>	<b>YES</b>	<b>NO</b>	<b>Gastrointestinal</b>	<b>YES</b>	<b>NO</b>	Intolerance To Heat	<input type="checkbox"/>	<input type="checkbox"/>
Wear Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance To Cold	<input type="checkbox"/>	<input type="checkbox"/>
Wear Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>
Vision Change	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam _____			Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergic / Immunologic</b>	<b>YES</b>	<b>NO</b>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood In Stools	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Black/tarry Stool	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>
			Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox Disease	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ears, Nose, Throat, Mouth</b>	<b>YES</b>	<b>NO</b>	Ulcer Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox Vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Ringin in Ears	<input type="checkbox"/>	<input type="checkbox"/>				Last Tetanus Booster _____		
Decreased Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<b>Urologic / Gynecologic</b>	<b>YES</b>	<b>NO</b>	Last Pneumonia Vaccine _____		
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pain With Urination	<input type="checkbox"/>	<input type="checkbox"/>			
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<b>Musculoskeletal</b>	<b>YES</b>	<b>NO</b>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Increased Urge To Urinate	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Up At Night Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Losing Urine Control	<input type="checkbox"/>	<input type="checkbox"/>	Recent Injuries / Falls	<input type="checkbox"/>	<input type="checkbox"/>
Last Dental Exam _____			Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>			
Voice Change	<input type="checkbox"/>	<input type="checkbox"/>				<b>Skin</b>	<b>YES</b>	<b>NO</b>
			Males:			Changing Moles	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory</b>	<b>YES</b>	<b>NO</b>	Difficulty With Erection	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Females:					
Short Of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Age Of First Menses _____			<b>Neurologic</b>	<b>YES</b>	<b>NO</b>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Regular Menses <input type="checkbox"/> <input type="checkbox"/>			Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Duration _____ Days			Numbness / Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Snoring/Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Cycle Interval _____ Days			Memory Changes	<input type="checkbox"/>	<input type="checkbox"/>
			Last Menses Started _____					
			Abnormal Pap Smear <input type="checkbox"/> <input type="checkbox"/>			<b>Social / Family</b>	<b>YES</b>	<b>NO</b>
						History Of Abuse	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUES ON REVERSE

Check here if your health history hasn't changed since your last visit.

**Present Concerns:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medical Conditions:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Hospitalizations:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Surgeries:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OBSTETRIC HISTORY:** (Fill in as appropriate)

Pregnancy Date(s)	Outcome (i.e. Vaginal Birth)
_____	_____
_____	_____
_____	_____

**SEXUAL HISTORY:** (Circle answers and fill in as appropriate)

Are you sexually active? YES NO NOT CURRENTLY

Sexual Partners: MALE(S) FEMALE(S) BOTH

Method of Contraception: \_\_\_\_\_

**HABITS:** (Circle answers and fill in as appropriate)

Tobacco? YES QUIT NEVER  
SMOKE CHEW SNUFF  
Amount Per Day \_\_\_\_\_  
Years Spent \_\_\_\_\_

Alcohol? YES QUIT NEVER  
Times per week \_\_\_\_\_  
Amount per time \_\_\_\_\_

Ever felt like you ought to cut down? YES NO  
Have people annoyed you by criticizing your drinking? YES NO  
Have you felt guilty about your drinking? YES NO  
Have you ever had an 'eye-opener' morning drink? YES NO

Other Drugs? YES QUIT NEVER  
(i.e. Marijuana) Which drugs? \_\_\_\_\_

Do you exercise regularly? YES NO  
Which exercises? \_\_\_\_\_

How many times per week? \_\_\_\_\_

Do you follow a special diet? YES NO  
Know your cholesterol levels? YES NO  
Total \_\_\_\_\_ HDL \_\_\_\_\_ LDL \_\_\_\_\_ Triglyceride \_\_\_\_\_

Wear seat belts? YES NO SOME  
Wear a bike helmet? YES NO SOME  
Have a smoke detector? YES NO  
Carbon monoxide detector? YES NO  
Adult / infant CPR training? YES NO  
If you own a gun, is it secured? YES NO N / A  
(Women) Self Breast Exam? YES NO  
(Women) Screening Mammogram? YES NO  
(Men) Self Testicular Exam? YES NO

**FAMILY:** (Circle answers and fill in as appropriate)

	LIVING	AGE	HEALTH CONDITIONS
MOTHER _____	Y N	_____	_____
FATHER _____	Y N	_____	_____
<b>SIBLINGS</b>			
1. M _____ F _____	Y N	_____	_____
2. M _____ F _____	Y N	_____	_____
3. M _____ F _____	Y N	_____	_____
4. M _____ F _____	Y N	_____	_____
5. M _____ F _____	Y N	_____	_____
6. M _____ F _____	Y N	_____	_____
<b>CHILDREN</b> (List names of children)			
1 _____	Y N	_____	_____
2 _____	Y N	_____	_____
3 _____	Y N	_____	_____
4 _____	Y N	_____	_____
5 _____	Y N	_____	_____