PLEASE PRINT THE EVERETT CLINIC PATIENT HISTORY INFORMATION PLEASE PRINT

NAME: First Middle Last _____

Date of Birth _____

Today's Date _____

DRUG ALLERGIES OR REACTIONS _____

_____

_____

_____

_____

_____

Occupation: _____

Marital Status: _____

MEDICAL HISTORY (List illness/surgery and dates)

CHRONIC ILLNESSES
HOSPITALIZATION
OR
PREVIOUS MAJOR
SURGERIES

Please check if you have or have had the following:

☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ HEART DISEASE ☐ LUNG PROBLEMS

☐ BLOOD CLOTS ☐ SEIZURES ☐ DEPRESSION / ANXIETY ☐ CANCER. Type_____

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS			
NUMBER _____			
SISTERS			
NUMBER _____			
CHILDREN			
NUMBER _____			

HAS ANY RELATIVE HAD THE FOLLOWING:

- ❑ Alcoholism _____
- ❑ Alzheimer's _____
- ❑ Anemia/Low Blood Count _____
- ❑ Lung Problems _____
- ❑ Cancer, Breast _____
- ❑ Cancer, Colon _____
- ❑ Cancer, Prostate _____
- ❑ Cancer, Other _____
- ❑ Heart Disease _____
- ❑ Depression _____
- ❑ Bipolar Disorder _____
- ❑ Diabetes _____
- ❑ Blood Clots _____
- ❑ Hearing Loss _____
- ❑ High Blood Pressure _____
- ❑ High Cholesterol _____
- ❑ Osteoporosis _____
- ❑ Stroke _____
- ❑ Other _____

PLEASE LIST CURRENT PRESCRIPTION MEDICATIONS, OVER THE COUNTER MEDICATIONS, AND HERBAL SUPPLEMENTS:

_____

_____

_____

_____

Are you taking aspirin daily? ☐ Yes ☐ No Birth Control Method: _____

Do you have any objections to a blood transfusion? ☐ Yes ☐ No

Immunization Shots

Dates of Last: Flu_____ Tetanus_____ Pneumonia_____ Hep A _____ Hep B _____

SOCIAL HISTORY

EXERCISE:
Type _____
_____
_____
How often? _____

SMOKING:
Packs per day _____
No of years _____
Year stopped _____
☐ Pipe ☐ Cigar ☐ Chew

ALCOHOL:
Drinks per day _____
Drinks per week _____
Alcohol problem: ☐ Yes ☐ No

RECREATIONAL DRUGS Y N

DO NOT SCAN/FILE
10-019 12/09

SAFETY [ ] I use seatbelts in car [ ] I have smoke detector in house [ ] I use Lifeline
[ ] Weapons in your home secured

SELF CARE Please check if you NEED HELP with any of these activities:

[ ] Dressing, [ ] Cooking meals, [ ] Bathing, [ ] Walking, [ ] Transportation

Do you currently have any of these Advance Directive forms?
[ ] Living Will [ ] Durable Power of Attorney for Healthcare [ ] Physician Orders for Life Sustaining Treatment (POLST)

PLEASE CHECK ALL THAT APPLY AND/OR WRITE IN OTHER PROBLEMS.

GENERAL HEALTH [ ] Fatigue [ ] Weakness [ ] Weight loss [ ] Ankle swelling [ ] Sleep problems
[ ] No problems [ ] Other _____

MENTAL HEALTH [ ] Memory problems [ ] Depressed [ ] Tense, nervous
[ ] No problems [ ] Other _____

BRAIN AND NERVES [ ] Fainting [ ] Poor balance [ ] One or more falls in past 6 months
[ ] No problems [ ] Other _____

URINARY [ ] Leaking bladder [ ] Difficulty urinating [ ] Sexual difficulty or concern
[ ] No problems [ ] Other _____

BONES AND MUSCLES [ ] Difficulty or pain with walking [ ] Painful joints
[ ] No problems [ ] Other _____

HEAD AND NECK [ ] Hearing problem [ ] Eyesight problem
[ ] No problems [ ] Other _____

BREATHING [ ] Cough [ ] Short of breath
[ ] No problems [ ] Other _____

HEART [ ] Chest pain or pressure [ ] Irregular heart beat [ ] Leg pain with walking
[ ] No problems [ ] Other _____

STOMACH AND BOWELS [ ] Swallowing trouble [ ] Indigestion [ ] Abdominal pain
[ ] Constipation [ ] Diarrhea [ ] Blood in stool or black stools
[ ] No problems [ ] Other _____

SKIN [ ] Rash [ ] Skin problems [ ] Skin cancer
[ ] No problems [ ] Other _____

Other [ ] Gonorrhea [ ] Herpes [ ] Chlamydia

WOMEN ONLY [ ] Abnormal Vaginal bleeding [ ] Vaginal Discharge [ ] Abnormal pap
[ ] Hot Flashes [ ] Breast lump [ ] Breast pain
[ ] No problems [ ] Other _____

Patient / Family Member _____ Date _____ Reviewed By MD/Initials _____

Please print patient name _____ Date of Birth _____