Please return this completed form prior to your visit with a provider

Patient Annual Health History

As a new patient and to help us understand any health issues that you may have, please fill out the information below to the best of your ability. We ask that you complete this form on annual basis so that we can provide you with exceptional care and monitor any changes in your health. All information is strictly confidential.

Patient Name:____**Date of Birth**:__________________**Intake Date**:___________________

Chief Complaint:____

Allergies:____**Last Physical:**____

DENTAL SECTION

Last Dental Exam:____

Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

Patient Medical History *Please check all that apply. Leave blank if unsure.*

☐ Measles	☐ Hemorrhoids	☐ Herpes	☐ High/Low Blood Pressure	☐ Anemia
☐ Mumps	☐ IBS/Diverticulitis	☐ Tuberculosis		☐ Arthritis
☐ Chicken Pox	☐ Crohn's Disease	☐ Bladder Infections	☐ Infectious Mono	☐ Heart Disease
☐ Diphtheria	☐ Ulcer	☐ Kidney Disease	☐ Hepatitis	☐ Aids/HIV
☐ Smallpox	☐ Glaucoma	☐ Hernia	☐ A ☐ B ☐ C	☐ Fibromyalgia
☐ Polio	☐ Epilepsy	☐ Back Trouble	☐ Blood/Plasma Transfusion	☐ Bronchitis
☐ Rheumatic Fever	☐ Diabetes	☐ STD		☐ Stroke
☐ Whooping Cough	☐ Cancer	☐ Head Injury	☐ Bruising	☐ Other:___________
☐ Pneumonia	☐ Chronic Fatigue	☐ Mitral Valve Prolapse	☐ Other: ____________	☐ Other: ___________

Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates: ______________________________________

____

Medications: **(Include inhalers, herbs, supplements and over-the-counter items):** _____________________________

____

Patient Social History:

Marital Status	**Alcohol Use**	**Smoking**	**Smokeless Tobacco**
☐ Single ☐ Separated ☐ Married ☐ Widowed ☐ Divorced	☐ Never ☐ Rarely ☐ Moderate ☐ Regularly Amount Per Day: __________	☐ Never ☐ Currently Amount Per Day: __________ ☐ Previously, but quit on date: ________________________	☐ Never ☐ Currently Amount Per Day: __________ ☐ Previously, but quit on date: ________________________
Caffeine Use ☐ Never ☐ Rarely ☐ Moderate ☐ Regularly Amount Per Day: __________	**Drug Use: Types** __________ ☐ Never ☐ Rarely ☐ Moderate ☐ Regularly Amount Per Day: __________	**Exercise Type:**__________ ☐ Never ☐ Rarely ☐ Moderate ☐ Regularly Amount Per Day: __________	**Traumatic Events:**

Family Medical History: *Please check if a family member has had any of the following and check the relationship to you;*

Diabetes	☐ Grandparent	☐ Mother	☐ Father	☐ Sibling	☐ Child
Cancer	☐ Grandparent	☐ Mother	☐ Father	☐ Sibling	☐ Child
Heart Disease	☐ Grandparent	☐ Mother	☐ Father	☐ Sibling	☐ Child
Hypertension	☐ Grandparent	☐ Mother	☐ Father	☐ Sibling	☐ Child
Death Before Age 50	☐ Grandparent	☐ Mother	☐ Father	☐ Sibling	☐ Child

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General Health (Past Year)
- ☐ Good
- ☐ Poor
- ☐ Recent Weight Change: _________lbs.
- ☐ Fatigue/Poor Energy
- ☐ Sleeping Problems/Snoring

Ear/Nose/Mouth/Throat
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Ear Infections
- ☐ Sinus Infections/Problems
- ☐ Nose Bleeds
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath/Bad Taste
- ☐ Sore Throat
- ☐ Swollen Gland in Neck
- ☐ Voice Change

Cardiovascular
- ☐ Last Cholesterol Screen Date: ________
- ☐ Heart Trouble/Attack
- ☐ Chest Pain/ Angina
- ☐ Heart Medications
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Shortness of Breath at Rest
- ☐ Pain in Legs
- ☐ Swelling in Ankles
- ☐ Varicose Veins
- ☐ Cold Extremities

Musculoskeletal/Pain
- ☐ Muscles Aches/Cramping
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Joint Stiffness
- ☐ Difficulty Walking Standing
- ☐ Osteoporosis
- ☐ History of Injuries and Accidents

Date:______________________

Details:____________________

Date:______________________

Details:____________________

Urinary Tract
- ☐ Frequent Urination
- ☐ Nighttime Urination
- ☐ Urgency/Burning/Painful Urination
- ☐ Blood In Urine
- ☐ Change in Urine Stream
- ☐ Incontinence or Dribbling
- ☐ Kidney Stones
- ☐ Sexual Difficulty
- ☐ Male: Testicle Pain
- ☐ Male: Last Prostate Check:___________

Skin/Breast/Immune System
- ☐ Rash/Itching/Hives
- ☐ Dry Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ New or Changing Moles
- ☐ Breast pain
- ☐ Breast Discharge
- ☐ Breast Lump
- ☐ Allergies:
  - ☐ Food ☐ Seasonal
  - ☐ Environmental:_______________
  - ☐ Other: ______________________
- ☐ Immune Deficiency/Compromise

Gastrointestinal
- ☐ Colon Cancer Screen Date:_________
- ☐ Appetite:
  - ☐ Good ☐ Poor ☐ Excessive
- ☐ Recent Change in Appetite
- ☐ Nausea or Vomiting
- ☐ Heartburn/Reflux
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Bowel Movements: # Per Day _____
  - ☐ Easy ☐ Difficult
- ☐ Skip Days of Moving Bowels
- ☐ Change in Bowel Habits
- ☐ Rectal Bleeding or Blood in Stool

Eyes
- ☐ Eye Disease or Injury
- ☐ Wear Glasses/Contacts
- ☐ Blurred Vision
- ☐ Double Vision

Neurological/Psychological
- ☐ Headaches
  - ☐ Daily ☐ Weekly
- ☐ Migraines
- ☐ Sinus Headaches
- ☐ Dizziness
- ☐ Light Headed
- ☐ Convulsions of Seizures
- ☐ Tremors
- ☐ Paralysis
- ☐ Numbness or Tingling
- ☐ Depression
- ☐ Anxiety/Nervousness
- ☐ Memory Loss/Confusion
- ☐ Abuse Survivor
- ☐ Trouble Sleeping

Female
- ☐ Last Period Start Date: ___________
- ☐ Periods Are:
  - ☐ Regular ☐ Irregular
- ☐ Monthly Cycle: # of Days ________
- ☐ PMS:
  - ☐ Irritability
  - ☐ Emotional
  - ☐ Breast Tenderness/Swelling
  - ☐ Other: __________________
- ☐ Vaginal Discharge or Itching
- ☐ # of Pregnancies: _______________
- ☐ # of Live Births: _________________
- ☐ Menopause Symptoms:
  - ☐ Hot Flashes
  - ☐ Night Sweats
  - ☐ Vaginal Dryness
  - ☐ Other: __________________
- ☐ Date of Last Mammogram: ________
  - ☐ Normal ☐ Abnormal
- ☐ Date of Last PAP Smear:
  - ☐ Normal ☐ Abnormal

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
- ☐ Coughing Up Blood