HEALTHFIRST
"Health care for the whole family"

Health History

DATE : ____/____/_____

Patient Name:_____ **Birth Date:**_____

Cardiac / Circulatory/ Vascular

- ☐ Heart Disease
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ Rheumatic/Scarlet Fever
- ☐ Coronary artery disease
- ☐ Edema (swelling)
- ☐ Peripheral vascular disease (PVD)
- ☐ Abdominal Aortic Aneurysm (AAA)
- ☐ Carotid artery stenosis (Clogged arteries)
- ☐ Atherosclerosis
- ☐ DVT(blood clot)
- ☐ Peripheral arterial disease (PAD)

Respiratory

- ☐ Lung Disease
- ☐ Asthma
- ☐ Pneumonia
- ☐ COPD/Emphysema
- ☐ Tuberculosis (TB)
- ☐ Pulmonary embolism (clot in the lung)

Muscular/Skeletal Disease

- ☐ Muscular/Skeletal Disease
- ☐ Rheumatoid Arthritis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Chronic back Pain
- ☐ Joint Replacement (Hip. Shoulder or Knee. Right or Left or both)

Neurological

- ☐ Stroke
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Epilepsy
- ☐ Parkinson's Disease
- ☐ Neurological disease
- ☐ Migraine/ Headaches
- ☐ Huntington's Disease

Endocrine

- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Hyper parathyroid
- ☐ Hypo parathyroid
- ☐ Diabetes type 1
- ☐ Diabetes type 2
- ☐ Gestational Diabetes
- ☐ Prediabetes

Liver / Kidney disease

- ☐ Liver/Kidney Disease
- ☐ Hepatitis A, B, C
- ☐ Dialysis (peritoneal / Hemodialysis)

Genitourinary

- ☐ Urinary Tract Infections
- ☐ Bladder Control
- ☐ Prostrate Problems

Skin Disease

- ☐ Eczema
- ☐ Psoriasis
- ☐ Rashes

Gastrointestinal

- ☐ Gastrointestinal Disease
- ☐ Diverticulosis
- ☐ IBS / Chron's Disease
- ☐ GERD

Cancer Type : _____

Vision

- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other

Psychological Illness

- ☐ Eating Disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Others_____

Others

- ☐ Sexually Transmitted Disease
- ☐ HIV
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Lyme Disease
- ☐ Measles
- ☐ Chicken Pox
- ☐ Rubella
- ☐ Frequent Ear Infections
- ☐ Rashes
- ☐ Mononucleosis
- ☐ Bleeding Disorder

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PLEASE LIST OF ALLERGIES TO FOOD, MEDICATION, XRAY DYES, VACCINES, AND ENVIRONMENTAL

_____

_____

_____

FAMILY HISTORY

LIST HEALTH PROBLEMS AND CAUSES OF DEATH, IF APPLICABLE

			Age	**Medical problems**
Father	Living	Deceased		
Mother	Living	Deceased		
Brother/s	Living	Deceased		
	Living	Deceased		
	Living	Deceased		
Sister/s	Living	Deceased		
	Living	Deceased		
	Living	Deceased		
Father's Father	Living	Deceased		
Father's Mother	Living	Deceased		
Mother's Father	Living	Deceased		
Mother's Mother	Living	Deceased		

MEDICATION AND /OR SUPPLEMENTS CURRENTLY TAKING (PLEASE ATTACH IF POSSIBLE)

_____

_____

_____

Pharmacy _____ Phone Number _____

DME /Equipment /02 supplier _____ Phone number_____

MY CONSIDERATIONS – additional needs for health maintenance

❑ Oxygen ❑ Injectable medication ❑ Wound care supplies ❑ Nebulizer ❑ CPAP/ BPAP ❑ Meals on Wheels

❑ Colostomy / catheter ❑ Feeding tube ❑ Wheelchair /assistive device

LIST ANY PAST SURGERIES OR HOSPITALIZATION /EMERGENCY ROOM VISIT SINCE LAST PROVIDER VISIT

Colon screening ☐Yes ☐No Date: Where?	Date: Where?	**Date**: **Where?**
Date: **Where?**	**Date**: **Where?**	**Date**: **Where?**
Date: **Where?**	**Date**: **Where?**	**Date**: **Where?**

LIST OF CHILDHOOD DISEASES

_____

_____

VACCINATION RECORD (IF AVAILABLE, ATTACH RECORD)

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Covid Vaccine / Date **Others :**

_____

_____

Women Only

Age Period Started_____ Are You Pregnant? ☐Yes ☐No

Last Period:_____ Number of Pregnancies_____

Last Pap Smear:_____ Number of Live Births_____

Any Abnormal Paps (yes/No)_____ Birth Control Method Used:_____

Date of Abnormal Pap_____

History of: (check all that apply) ☐ Colposcopy ☐ Leep ☐ Hysterectomy Dates: _____ _____

Self Breast Exam ☐Yes ☐No Mammogram ☐Yes ☐No **Date**:_____ **Where?**_____

LIST ANY PHYSICIANS OR PROVIDERS YOU CURRENTLY SEE

Name	Specialty	Contact Number