HC HIGHLAND CLINIC

PATIENT HISTORY FORM

Fax to 4451

Name:_____DOB:_____Age:_____

Reason for Visit:_____

Allergies: _____

Medications: *Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc)*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Past Medical History:

Do you have?

- ☐ None
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Thyroid Disease
- ☐ Other_____
- ☐ Cancer
- ☐ Depression
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Gout
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure
- ☐ GERD
- ☐ Bowel/Bladder
- ☐ None

Past Surgical History:

Have you had?

- ☐ Thyroid
- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Gallbladder
- ☐ Tonsillectomy
- ☐ Other _____
- ☐ _____
- ☐ None

Health Maintenance:

	Date of last		Date of last
Last Pap/Pelvic	_____	Eye Exam	_____
Mammogram	_____	Tetanus	_____
Rectal	_____	Flu	_____
Pneumovax	_____	Other	_____
PSA	_____		
Colonoscopy	_____		

Social History:

Occupation:_____

- ☐ Drugs _____
- ☐ Tobacco Use Yes No How long?____
- ☐ Alcohol Use Yes No
- ☐ Transfusions Yes No

Married Divorced Widowed

Family History:

- ☐ High Blood Pressure Who:_____
- ☐ Heart Disease Who:_____
- ☐ Diabetes Who:_____
- ☐ Osteoporosis Who:_____
- ☐ Other_____ ☐ None
- ☐ Cancer Who:_____
- ☐ Depression Who:_____
- ☐ Kidney Disease Who:_____

Review of Systems: Do you have?

- ☐ Fatigue
- ☐ Chills
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Skin Rash
- ☐ Skin Lesion
- ☐ Chronic Headache
- ☐ Constipation
- ☐ Reflux
- ☐ Blood in Stool
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Seizures
- ☐ Depression
- ☐ Bruising
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Asthma