PATIENT HEALTH HISTORY

Today's Date: ______________
Patient Name: ____ Date of Birth: ______________

Patient Height ______________ Patient Weight ________________

Chief Complaint

Reason for today's visit? ____

Current problem is the result of a(n): Check all that apply
☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other ________________________________
Date of onset _______________________

Past History

Please list any prior major illnesses and/or injuries: _______________________________________
____
____
____

It is essential that Dr. Johans has your surgical history as accurately as you are able to convey. Operative notes from past surgeons would be very helpful if the surgery is related to your present issue.

Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia? ☐ Yes ☐ No
Do you take Aspirin? ☐ Yes ☐ No If Yes, how often : __________________________

Current Medications **Including Over the Counter**	Dose	Frequency

Please write down medications on Intake Form exactly as is written on prescription or obtain pharmacy records .

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Patient Name: ____ Date of Birth: _______________

ALLERGIES/TYPES OF REACTIONS
Please circle: **Latex** Yes No **Iodine** Yes No **Shellfish** Yes No **Asthma** Yes No

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Do you have children? ☐ Yes ☐ No How many? __________________

Do you live alone? ☐ Yes ☐ No Who lives with you? ___________________________________

Do you smoke? ☐ Yes, I've smoked _______ packs of cigarettes per day for _____________ years.
☐ Yes, I smoke cigars or a pipe.
☐ No, I have never smoked.
☐ No, I quit ______ years ago. At that time I was smoking ______ packs per day for ______ years.

Do you drink alcohol? ☐ No, never (or rarely) ☐ No, but I used to
☐ Yes ☐ Daily ☐ 1 or more times a week ☐1 or more times a month

Are you at risk for AIDS (e.g., sexual orientation, drug abuse, previous blood transfusion)?
☐ No ☐ Yes, please explain ____

☐ Deferred by patient: Signature ____

Today's Date: ______________

Patient Name ____ Date of Birth: ______________

REVIEW OF SYSTEMS

Do you currently have any problems with:

Eyes	Circle One
Blurred or double vision……………	Yes No
Glaucoma…………………………..	Yes No
Any other…………………………..	Yes No

Gastrointestinal	
Nausea or vomiting………………….	Yes No
Change in bowel movements………..	Yes No
Any other……………………………	Yes No

Psychiatric	
Memory loss or confusion…………..	Yes No
Depression…………………………..	Yes No
Any other……………………………	Yes No

Cardiovascular	
Heart Trouble……………………….	Yes No
Chest pain or angina pectoris……….	Yes No
Hypertension………………………..	Yes No
Any other……………………………	Yes No

Constitutional	
Recent weight change……………….	Yes No
Fever………………………………..	Yes No
Headaches…………………………...	Yes No
Any other…………………………...	Yes No

Neurological	
Light headed or dizzy……………….	Yes No
Convulsions or seizures……………..	Yes No
Numbness or tingling………………..	Yes No
Tremors……………………………....	Yes No
Paralysis……………………………..	Yes No
Stroke………………………………..	Yes No
Head Injury………………………….	Yes No
Any other……………………………	Yes No

Ear, Nose, Mouth, & Throat	Circle One
Hearing loss or ringing…………….	Yes No
Earaches or drainage……………….	Yes No
Any other…………………………..	Yes No

Genitourinary	
Frequent urination………………….	Yes No
Burning or painful urination………..	Yes No
Any other…………………………..	Yes No

Endocrine	
Diabetes……………………………..	Yes No
Glandular or hormone problem……..	Yes No
Any other……………………………	Yes No

Respiratory	
Shortness of breath…………………..	Yes No
Spitting up of blood………………….	Yes No
Asthma or wheezing…………………	Yes No
Any other…………………………….	Yes No

Musculoskeletal	
Joint pain……………………………..	Yes No
Weakness of muscles or joints……….	Yes No
Neck or back pain…………………….	Yes No
Any other……………………………..	Yes No

The above information is accurate to the best of my knowledge

____ ____________________

Patient Signature Date

I have reviewed the above information with the patient

____ ____________________

Physician printed name & signature Date