



(Established) Patient's Personal History Form

Today's Date _____

Name: _____
 (LAST NAME) (FIRST NAME) (MIDDLE NAME) (PREFERRED NAME)
 Address _____ City _____ State _____ Zip _____
 Phone (Home) _____ Phone (Cell) _____ Phone (Work) _____
 Email _____ DOB: _____ Sex: Male Female
 Insurance Name _____ Group # _____ ID # _____
 Primary Pharmacy _____ Location _____
 Current Agency (Fire/Police/EMS): _____ Special Operations Team(s) _____

Health History Updates

Please update any medical history SINCE last wellness examination with ERHC.

| Medications (prescription, OTC, vitamins) and Dosages: | Medication Allergies (specify type of reaction) |
|---|---|
| 1. | Latex or adhesives? Yes No (circle) |
| 2. | |
| 3. | |
| 4. | |
| 5. | Hospitalizations/Injuries: |
| 6. | |
| 7. | |
| 8. | |
| Health Care Providers or Specialists (please list) | Surgeries (type, date, surgeon, and hospital – if known): |
| | |
| | |
| | |
| | |
| Any recent concerning occupational exposures or injuries? | |
| | |

Preventative Health Screening since last wellness exam

Laboratory testing: _____ / _____
 (DATE) (LOCATION)
 Colonoscopy: _____ / _____ Stool guiac: _____ / _____
 (DATE) (LOCATION) (DATE) (LOCATION)
 Dental exam: _____ / _____ Vision exam: _____ / _____
 (DATE) (LOCATION) (DATE) (LOCATION)
 PAP Smear: _____ / _____ Mammogram: _____ / _____

Social History Update/Changes

Marital Status: _____
 Work change: _____
 Tobacco use: Yes or No (chew or smoke)
 Alcohol use: Never, occ., weekly, daily
 Caffeine use: Never, occ., weekly, daily
 Drug use: Yes or No (type)

What are your goals for your health: _____

Specific topics you would like to discuss today? _____

(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

(SIGNATURE OF PHYSICIAN/PROVIDER)

Patient Self Evaluation and Review of Systems

Please review each item below and check any items that **currently** apply to you.

| System and Problem | X | Describe | System and Problem | X | Describe |
|--|---|----------|---|---|----------|
| General | | | Genital – Male | | |
| Fevers or chills | | | Reduced urinary flow | | |
| Night sweats / Hot flashes | | | Frequent nighttime awakening to urinate | | |
| Significant fatigue | | | Difficulty with erection | | |
| Unusual bleeding or bruising | | | Lump/mass on testicle or in scrotum | | |
| Swollen glands | | | Penile lesion, discharge or concerning rash | | |
| Unintended weight loss or gain | | | Difficulty with sexual relations | | |
| Allergy and Immunologic | | | Genital – Female | | |
| Hay fever | | | Recent change in menses | | |
| Itchy, watery eyes or nose | | | Increasing pain with menses | | |
| Frequent itchy, sensitive skin | | | Vaginal irritation, burning or discharge | | |
| Persistent clear nasal drainage | | | Breast pain or tenderness | | |
| Excessive or frequent infections | | | Breast lump or nipple discharge | | |
| Eyes, Ears, Nose, Throat, Neck | | | Concerning rash | | |
| Dramatic changes in vision | | | Difficulty with sexual relations | | |
| Use of glasses or contacts | | | Dermatology | | |
| Loss of hearing or use of hearing aids | | | Changing mole, bump, or growth | | |
| Earache or drainage | | | Rash or skin problems | | |
| Ringing in ears | | | Musculoskeletal | | |
| Nose bleeds | | | Joint aches or pains | | |
| Sinus pressure or pain | | | Joint swelling | | |
| Sore throat | | | Significant morning stiffness | | |
| Excessive snoring | | | Back pain | | |
| Hoarseness more than 2 weeks | | | Numbness/tingling extremities | | |
| Cardiovascular | | | Lymphatic | | |
| Chest pain or pressure with exertion | | | Neck, armpit, or groin - swollen glands | | |
| Unusual shortness of breath | | | Neurologic | | |
| Palpitations | | | New or more severe headaches | | |
| Irregular heart beats | | | Lightheadedness or fainting | | |
| Increasing calf pain with walking | | | Unexplained loss of muscle strength | | |
| Wounds with poor healing | | | Trouble with balance | | |
| Swelling of extremities | | | Memory loss | | |
| Unable to sleep lying flat | | | Difficulty with complex thought process | | |
| Respiratory | | | Endocrine | | |
| Worsening asthma or allergy symptoms | | | Markedly increased thirst or urination | | |
| Chronic cough | | | Intolerance of heat or cold | | |
| Blood tinged sputum | | | Excessive fatigue or loss of motivation | | |
| Pain with deep breathing | | | Decrease in libido | | |
| Difficulty breathing | | | Psychiatric | | |
| Gastrointestinal | | | Feeling sad, blue, irritable, angry | | |
| Abdominal pain | | | Feeling anxious | | |
| Frequent heartburn | | | Decreased interest in hobbies | | |
| Pain or difficulty swallowing | | | Suicidal thoughts | | |
| Frequent nausea or vomiting | | | Preoccupations or compulsion | | |
| Change in bowel habits | | | Difficulty with completion of tasks | | |
| Increased constipation | | | Others concerns or comments: | | |
| Frequent diarrhea | | | | | |
| Blood in stool or on toilet paper | | | | | |
| Black, tarry stools | | | | | |
| Urinary | | | | | |
| Burning with urination | | | | | |
| Increased urinary urgency or frequency | | | | | |
| Blood in urine | | | | | |