NORTH EMERGENCY RESPONDERS HC

EMERGENCY RESPONDERS HEALTH CENTER

Today's Date _____
Patient Name _____
Date of Birth_____
Preferred Phone _____
Email _____

NEW PATIENT – PERSONAL HISTORY FORM

Confidential

NAME: _____
(LAST NAME) (FIRST NAME) (MIDDLE NAME) (PREFERRED NAME)

AGE: _____ SEX: □ MALE □ FEMALE LAST PHYSICAL EXAM _____/_____
(DATE) (PRIMARY CARE PROVIDER)

CURRENT FIRE, POLICE OR EMS AGENCY: _____ YEARS OF SERVICE: _____

PRIMARY PHARMACY _____ LOCATION _____

CURRENT FIRE, POLICE OR EMS AGENCY: _____ YEARS OF SERVICE: _____

SPECIAL OPERATIONS TEAM(S) Circle: ***HAZMAT*** ***DIVE*** ***TECH RESCUE*** ***CLAN LAB*** ***OTHER***_____

Health History

Medications (prescription, OTC, vitamins) and Dosages:	**Medication Allergies (specify type of reaction)**
1.	**Latex:** (circle) Yes No **Adhesives:** Yes No
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 exposures or injuries?	

CONDITIONS: Check those you have or have had in the past:

___ Alcoholism
___ Anemia
___ Anorexia
___ Arthritis
___ Asthma
___ Back pain
___ Bleeding Disorder
___ Breast lump
___ Bronchitis
___ Eating Disorder
___ Chemical Dependency
___ Crohn's
___ Depression
___ Diabetes
___ Glaucoma
___ Gout
___ Heart attack
___ Heart problems
___ Hepatitis
___ Hernia
___ Herpes (HSV)
___ High blood pressure
___ High cholesterol
___ HIV positive
___ Kidney disease
___ Liver disease
___ Lung disease
___ Migraines
___ Miscarriage
___ Pneumonia
___ Prostate problems
___ Psychiatric care
___ Rheumatic fever
___ Seizures
___ Snoring/Sleep apnea
___ Stomach issues
___ Stomach ulcers
___ Stroke/TIA
___ Suicide attempt
___ Thyroid issues
___ Tuberculosis
___ West Nile Virus
___ Cancer(s)
_____
_____

Immunizations

When did you last have? (MM/YY)

Hepatitis A (2 shots) _____
Hepatitis B (3 shots) _____
Hepatitis B blood titer Pos_ or Neg_
Tetanus booster _____
MMR _____ Polio _____
Influenza/flu shot _____
Tuberculin skin test_____
Pneumovax _____
Shingles _____
Others _____

Other conditions not listed:

_____
_____
_____

Patient Name _____

Social Health History

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated **Spouse's Name** _____

Children: How many? _____ Birth years & names:

Race: □ Native American □ Asian □ Black/African American □ White □ Hispanic □ Pacific Islander □ Other Race

Occupation: _____ □ FT □ PT □ Self □ Retired from:_____

Level of Education: □ High School/GED □ Tech/Associates □ Bachelor's or Higher

Diet: □ Unrestricted □ Low fat □ Low carb/diabetic □ **Caffeine**: □ Yes □ No **Energy drinks:** □ Yes □ No

How often do you eat out? □ Daily □ 2-3 x/week □ Once per week □ 2-3 x/month

Sleep: # of hours per night _____ **Problems**: Falling / Staying asleep? □ No □ Yes

Exercise: □ No □ Yes Type:_____

Exercise frequency/week: _____ Total minutes of exercise/week: _____

Safety: Are you experiencing neglect and/or abuse in any of your relationships? □ No □ Past □ Current

Street Drugs: □ Never □ Past □ Current What?_____ Started: _____ Quit: _____

Tobacco: □ Never □ Past _____ _____ □ Current □ Smoke -- Packs per day? _____

(STARTED) (QUIT) □ Chew ---- Cans per day? _____

Alcohol: □ Never □ Past □ Current Type: _____ _____# drinks per □ Day □ Week □ Month

(LIQOUR, BEER, WINE)

Has anyone, including your family, ever said that drinking might be causing a problem for you? □ Yes □ No

Family History

Family history is an important part of your health history to consider illness prevention and health promotion.

- Please include estimated age of onset of any known disease (i.e. Father, heart attack, age 52).
- Please place a circle around any check mark if cause of death and include estimated age death.

	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Siblings	Other
Atherosclerotic Disease								
• Health attack (MI)								
• Stroke (CVA)								
• Heart disease (other)								
Metabolic disease								
• High Blood Pressure/HTN								
• ↑ Cholesterol/lipids								
• Diabetes (type I or type II)								
• Gout								
• Osteoporosis								
• Clotting disorder								
Endocrine								
• Thyroid disease; other								
Cancer - Specify • colon, breast, prostate, other								
Neurodegenerative - Specify • Dementia, Parkinson's, ALS,etc								
Autoimmune (RA, Lupus, etc.)								
Mental Health – Specify • Depression, other								
Alcoholism (or other substances)								
Other(s):								

Patient Name _____

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					

Patient Name _____

Sexual Health Screening (Voluntary)

Are you sexually active? □ Yes □ No
Are you planning a pregnancy? □ Yes □ No
Birth control method(s) currently using:
□ Hormone contraceptive □ IUD
□ NuvaRing □ Condoms
□ Withdrawal □ Spermicide
□ Tubal ligation □ Vasectomy
Other: _____
Any concerns of infertility? □ Yes □ No
Risk/concerns for sexually transmitted disease?
□ Yes □ No
Would you like to speak with a provider about testing?
□ Yes □ No

Females Only Section

Have you ever been pregnant? □ Yes □ No
How many times? _____
How many miscarriages? _____
How many abortions? _____
How many children do you have living? _____
Do you have menstrual periods? □ Yes □ No
If no, at what age did they stop? _____
If yes, are your periods regular? _____
History of abnormal Pap Smear?
If yes, list date(s), provider name and treatment:
_____

Past Preventative Health Screening

Laboratory screening (cholesterol, glucose, etc.) _____/_____
(DATE) (LOCATION)

Pap smear (female): _____/_____ **Mammogram (female):** _____/_____
(DATE) (PROVIDER/LOCATION) (DATE) (LOCATION)

DEXA (bone density): _____/_____ **Dermatology consult:** _____/_____
(DATE) (LOCATION) (DATE) (PROVIDER)

Dental exam: _____/_____ **Vision exam:** _____/_____
(DATE) (PROVIDER/LOCATION) (DATE) (PROVIDER/LOCATION)

Colonoscopy: _____/_____ **EGD (upper endoscopy)** _____/_____
(DATE) (PROVIDER/LOCATION) (DATE) (PROVIDER/LOCATION

What are your goals for your health: _____
_____
_____
In the next year? _____
_____
_____
In the next 5 years? _____
_____
_____

_____
(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

_____
(AUTHORITY OF RELATIONSHIP TO PATIENT)

_____
(DATE)

Initial Review by Provider: _____/_____
(DATE) (INITIAL)

Subsequent Reviews:

PATIENT	PROVIDER
_____/_____	_____/_____
_____/_____	_____/_____
_____/_____	_____/_____