Thank you for Choosing

Patient History Form

Date	Time	
Patient Name		
Address		
City	State	Zip
Phone#	Cell #	
Contact Name	Phone #	

Date of Birth	Sex		Social Security
	Male	Female	

Physicians (please fill in)

	Name	Phone	City / State
Primary			
Referring			
Diabetic			
Surgeon			

Name of Home Health:	Phone #	Contact Person:	Date services began:
Name of Pharmacy:	Phone #		

Medication List

Please list any medications you are currently taking or attach a list

Name of Medication	Quantity (amount per day)	Actively Taking

Allergies

Chronic Conditions or Illnesses	Duration	Active	Inactive

Hospitalizations	Year	Physician or Facility

Surgeries/ Procedures	Year	Physician or Facility

History of Illnesses and Conditions
(please check all that apply)

Cardiovascular –Heart

- chest pain
- arrhythmia
- heart failure
- high blood pressure
- low blood pressure
- heart attack
- heart murmur
- short of breath laying down
- short of breath on exertion
- palpitations
- pacemaker

Constitutional

- fever
- weight loss
- chills
- night sweats
- excessive thirst

Gastrointestinal

- Anorexia
- liver problems
- bowel incontinence
- change in appetite
- Cirrhosis
- Diarrhea
- swallowing problems
- Hepatitis
- yellow jaundice
- malnutrition
- blood in stools
- Obesity
- recent weight gain or loss

Cardovascular - Peripheral

- blood clots in legs
- leg swelling
- vein surgery
- claudication
- rest pain
- necrosis/gangrene
- leg cramps
- peripheral vascular disease

Endocrine

- hot flashes
- goiter
- diabetes
- intolerance to cold
- intolerance to heat
- low blood sugar
- thyroid problems

Eyes

- Cataracts
- contacts
- glasses
- Glaucoma
- visual changes

ENT

- dentures
- difficult swallowing
- hearing loss
- cold sores
- eustachian tube dysfunction
- recent URI or Flu
- sinus surgery
- sinus allergies
- sore throat
- dental problems

Nutrition

- Supplemental nutrition
- Herbal supplements
- TPN or feeding tube
- Require a dietary consult

Immunologic

- Lupus Erythematosis
- Rheumatoid arthritis
- Scleroderma
- on steroid medications

Musculoskeletal

- Osteoarthritis
- joint stiffness
- joint swelling
- myalgia
- Gout

Neurologic

- Stroke
- dizziness
- Migraine Headaches
- Muscular Dystrophy
- seizures
- spinal cord injury
- syncope
- TIA/ mini strokes

Respiratory

- Asthma
- Bronchitis
- COPD
- cold symptoms
- cough
- Emphysema
- shortness of breath
- Tuberculosis
- wheezing
- collapsed lung

Genitourinary

- kidney disease
- transplant
- kidney stones
- blood in urine
- incontinence
- frequency
- Venereal disease
- prostate problems

Hematological

- Anemia
- abnormal bleeding
- bleeding disorder
- AIDS
- Cancer
- high cholesterol
- HIV positive
- blood transfusion
- Tuberculosis skin test

Psychological

- Depression
- Alcoholism
- chemical dependency
- under psychological care
- suicide attempt

Skin

- dryness
- keloids
- itching
- rashes
- nail problems

			ulcers or sores	

Past Family Social History

Marital Status

Single	
Married	
Divorced	
Widow	

Living Conditions

Alone	
With family	
Nursing Facility	
Other	

Needs

Patient has family or friend who can assist with care	
Yes	No
Needs Home Health Assistance?	

Work History

Occupation	
Retired because	
Present activity	

Health Habits

Do you smoke? (If so please state how long and how much daily)

Yes	No	Amount
Alcohol		
Coffee		
Caffeine		
Recreational Drugs		

Other Note:

Family Members cause of Death

Mother	Father	Children		