PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____

Zip: _____

Phone (Home/Cell): _____ Work Phone: _____

Reason for Consult (circle one): Surgical Non-Surgical Unsure

SOCIAL HISTORY

Work (Circle one): Unemployed Disabled Full-time Part-time Retired

Type of work: _____

Marital Status: Married Divorced Single Widowed Life partner

Current Stress level: (1 no stress to 10 highest stress ever had) _____

Smoke cigarettes: Yes No Number of packs/day: _____

Previous smoker: Yes No Quit date: _____

Electronic cigarettes/vaping: Yes No Number of times per day: _____

Cigars/pipe: Yes No Number of cigars/pipes per day: _____

Hookah: Yes No

Chew tobacco: Yes No

Drink alcohol: Yes / No Number of drinks per day: _____ Per week: _____ Per month: _____ Past use:_____

Past Treatment for addiction _____

Illicit Drugs: Yes / No Drug of choice: _____ Past use:_____

Past Treatment for addiction _____ Current use: _____

Cardiovascular	**Yes**
High blood pressure	_____
Congestive heart failure	_____
Heart stress test	_____
Heart attack	_____
Heart catheterization	_____
Stents placed in Heart	_____
Angina/chest pain	_____
Peripheral vascular disease	_____
Stroke	_____
Lower leg edema/swelling	_____
Blood clot in leg or lung	_____
Vena Cava heart filter	_____

Pulmonary	**Yes**
COPD	_____
Asthma	_____
Inhaler use	_____
Oxygen use at home	_____
Pulmonary hypertension	_____
Obstructive sleep apnea	_____
Use of CPAP/BIPAP at night	_____

Musculoskeletal	**Yes**
Back pain	_____
Joint pain	_____
Fibromyalgia	_____

Place Patient Label Here

EPIC: ENC level to Patient Self Assessment - Scan
Description: Health History
Form M1408d (Rev. 07/2020)

Gastrointestinal	**Yes**
Heartburn/reflux/GERD	_____
Heartburn medication	_____
Past anti-reflux surgery	_____
Barrett's Esophagitis	_____
Crohn's Disease or Colitis	_____
Abnormal liver test	_____

Reproductive	**Yes**
Polycystic Ovarian Syndrome	_____
Infertility	_____
Menstrual irregularities	_____

Metabolic	**Yes**
Diabetes, Type 1	_____
Diabetes, Type 2	_____
Fasting glucose > 99mg/dl	_____
Oral medication for Diabetes	_____
Insulin use	_____
Gestational Diabetes	_____
Kidney problems	_____
On dialysis	_____
High cholesterol/lipids	_____
Gout	_____
Thyroid	_____

Past Surgical History (List any surgeries and dates)

_____

_____

_____

_____

Family History:

	Mother	**Father**	**Maternal grandparent**	**Paternal grandparent**	**Siblings**	**Other**
Obesity						
Heart disease						
Thyroid disease						
Stroke						
Cancer (type)						
Diabetes Mellitus						