

# SPECIALIST CENTER HEALTH HISTORY

PCP: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
LAST FIRST MIDDLE

Height: \_\_\_\_\_ feet \_\_\_\_\_ inches Weight: \_\_\_\_\_ pounds Dominant Hand:  R  L

If female, are you or could you be pregnant?  No  Yes

Reason for today's visit: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of injury or onset of problem: \_\_\_\_\_

Is this work related?  No  Yes Reported to employer?  No  Yes

Is this related to an accident?  No  Yes  Auto  Other \_\_\_\_\_

Do you have legal action pending regarding this?  No  Yes Name of Attorney: \_\_\_\_\_

**MEDICATIONS/ALLERGIES:**

List all current medications:

Name	Strength	How many tablets do you take each day?	Doctor Prescribing
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all drug, non-drug / food allergies or reactions:  No Drug Allergy  No Food Allergy  No Latex Allergy

**PAST SURGICAL HISTORY:**

Have you ever had any problems with anesthesia?  No  Yes  Explain \_\_\_\_\_

Have you ever had any surgeries?  No  Yes (If yes, please write them below)

Type	Date	Type	Date
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY HISTORY:**

	Mother	Father	Brother	Sister		Mother	Father	Brother	Sister
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER – explain _____				

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# SPECIALIST CENTER HEALTH HISTORY

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
LAST FIRST MIDDLE

**REVIEW OF SYSTEMS:**

Are you currently having or have you had problems with:

	NO	YES		NO	YES
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Lungs, Breathing, Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Bladder / Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems / Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Blackout / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Numbness / Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS / Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Reaction	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Old Fracture	<input type="checkbox"/>	<input type="checkbox"/>	Wound Infection	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis / Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Describe all "Yes" responses: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_

Smoker       No     Yes    \_\_\_\_\_ packs per day for \_\_\_\_\_ years

Quit smoking     No     Yes    When? \_\_\_\_\_

Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years

Chew tobacco?     No     Yes    How much? \_\_\_\_\_

Drink alcohol?     No     Yes    How much and how often? \_\_\_\_\_

History of substance abuse / recreational drugs?     No     Yes    What? \_\_\_\_\_

Do you live alone?     No     Yes

Children?     No     Yes    # \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Reviewed by** \_\_\_\_\_ **Date** \_\_\_\_\_

**MD Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Update \_\_\_\_\_ by \_\_\_\_\_ Update \_\_\_\_\_ by \_\_\_\_\_

Update \_\_\_\_\_ by \_\_\_\_\_ Update \_\_\_\_\_ by \_\_\_\_\_