SCOTT&WHITE Healthcare

PATIENT HISTORY WORKSHEET

Please complete this entire 4 page form to allow us to update your prior information into our shared Electronic Medical Record

Full Name:

Address:

City, State, Zip:

Date of Birth:

Date of Service:

Gender: ☐ Male ☐ Female

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

MEDICATIONS

List any medications you take, prescription and nonprescription, and their dosage: ☐ **No medications**

	Medication	**Dose**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

Preferred Pharmacy

Pharmacy: _____ Phone Number: _____

Address: _____ City: _____

ALLERGIES & REACTIONS

Please list any significant reactions you have to medications or foods:

☐ **None**

Medications:
- Aspirin:
- Penicillin:
- Sulfa (Bactrim):
- Others:

Latex:

IV Contrast:

Insect Stings:

Food Reactions:

For Office Use Only: Form to be SHREDDED after abstraction. Not for scanning into Med Rec

Patient Name: _____ Abstracted on: _____by: _____

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PAST MEDICAL HISTORY

Please indicate if you have ever experienced any of the following conditions. Please include the date of onset.

X	DISEASE	YEAR
	Alcohol Dependence	
	Allergies	
	Anemia	
	Angina	
	Anxiety	
	Arthritis	
	Asthma	
	Blood Clots	
	Broken Bones	
	Cancer (including type):	
	Celiac Disease	
	Chronic Back Pain	
	Chronic Blood Thinner Use	
	Chronic Bronchitis	
	Chronic Fatigue Syndrome	
	Chronic Hepatitis	
	Chronic Kidney Disease	
	Chronic Neck Pain	
	Chronic Pain	
	Chronic Sinusitis	
	Circulatory Disease	
	Colitis	

X	DISEASE	YEAR
	Depression	
	Diabetes Type I	
	Diabetes Type II	
	Diarrhea, Chronic	
	Disc Disease (spine)	
	Drug Abuse or Addiction	
	Emphysema / COPD	
	Gallbladder / Stones	
	Goiter, Neck	
	Gout	
	Headache	
	Heart Attack	
	Heart Disease (other):	
	Heart Failure	
	Hepatitis	
	High Blood Pressure	
	HIgh Blood Sugar	
	High Cholesterol	
	Insomnia	
	Irregular Heart Rhythm	
	Irritable Bowel Syndrome	
	Kidney Stones	
	Other Kidney Disease:	

X	DISEASE	YEAR
	Liver Disease	
	Low Blood Pressure	
	Low Blood Sugar	
	Migraine Headaches	
	Obesity	
	Osteoporosis	
	Palpitations	
	Reflux (GERD)	
	Rheumatoid Arthritis	
	Sciatica	
	Seizures/Epilepsy	
	Sleep Apnea (OSA)	
	Stomach Ulcer	
	Stroke (CVA)	
	Throid Disease (high)	
	Thyroid Disease (low)	
	Tinnitus (ear ringing)	
	Tubculosis	
	Ulcers	
	Other:	

SURGICAL HISTORY

Please check all that apply.

	Date		Date		Date
☐ Angioplasty—Heart Balloon	_____	☐ Gallbladder	_____	☐ Liver biopsy	_____
☐ Angioplasty w/ Stent	_____	☐ Colon removal	_____	☐ Bone Fracture surgery (pins &/or plates-ORIF)	_____
☐ Appendectomy	_____	☐ Colostomy (bag)	_____	☐ Pacemaker	_____
☐ Knee Scope surgery	_____	☐ Gastric bypass	_____	☐ Small bowel removal	_____
☐ Back surgery	_____	☐ Hernia repair	_____	☐ Thyroid removal	_____
☐ Coronary Artery Bypass Graft	_____	☐ Hip replacement	_____	☐ Tonsillectomy	_____
☐ Carpal Tunnel release	_____	☐ Knee replacement	_____		
☐ Cataract extraction	_____	☐ LASIK vision surgery	_____		

☐ Other: _____ _____

Female Surgical History

	Date		Date
☐ Bilateral Tubal Ligation	_____	☐ Hysterectomy Partial (Cervix & uterus, left tubes and ovaries)	_____
☐ Breast biopsy	_____	☐ Total Hysterectomy—Abdominal cut + ovaries	_____
☐ Breast enlargement or reduction	_____	☐ Vaginal Hysterectomy—Uterus only	_____
☐ Breast cancer surgery (Mastectomy)	_____	Uterus and Ovaries	_____
☐ Cesarean section	_____	☐ Uterus Fibroid removal (Myomectomy)	_____
☐ D & C (Dilation and curettage)	_____		
☐ Other: _____	_____		

Male Surgical History

	Date		Date
☐ Prostate biopsy	_____	☐ Vasectomy	_____
☐ TURP (Trans-Urethral Resection of the Prostate)	_____	☐ Other: _____	_____

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FAMILY HISTORY

☐ **Adopted (go to the next page)**

Family Member:	Name(s):	Oldest Age	Living	If Deceased Cause of Death
Mother				
Mother's Mother				
Mother's Father				
Father				
Father's Mother				
Father's Father				
Brother(s)				
Sister(s)				
Child(ren)				

Please mark "X" all your family member's condition & the Age at onset.

X	Disease	Mom	Mom's parents		Dad	Dad's Parents		Siblings		Children	
			Mother	Father		Mother	Father	Bro	Sis		
	Attention Deficit D.O.										
	Alcoholism										
	Allergies										
	Alzheimer's disease										
	Asthma										
	Blood disease										
	Heart disease										
	Heart disease before age 50										
	Cancer										
	Type: _____										
	Depression										
	Developmental delay										
	Diabetes										
	Eczema										
	Hearing Loss										
	High cholesterol										
	Hypertension										
	Inflammatory Bowel Disease										
	Kidney disease										
	Learning disability										
	Mental illness										
	Migraine Headaches										
	Obesity										
	Osteoporosis										
	Peripheral Vascular Disease										
	Seizures/epilepsy										
	Stroke (CVA)										
	Other:										

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SOCIAL HISTORY

Family Status

Marital Status: ☐ Single ☐ Divorced X _____ ☐ Separated ☐ Widowed X_____

☐ Married—Current Marriage #:_____ Spouse Name: _____

Children (Names & Ages)

Sons:

Daughters:

Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Other: _____

_____ _____

Name of Employer (Company Name) Occupation

Education

Highest level completed: _____

Current School & Grade (if applicable): _____

Habits

TOBACCO USE? ☐ Yes ☐ Never ☐ Former Year Quit? _____ Total Years smoked? _____

Packs per Day?: _____ Packs (or cans/pouches) per day? _____

Other Tobacco units per day (cans, cigars, etc)? _____

Units per day? _____ # of Years used?_____ Year Quit? _____

CAFFEINE USE? ☐ Yes ☐ No Type & Amount:

☐ Coffee:_____ ☐ Tea:_____ ☐ Soda:_____ ☐ Chocolate:_____

ALCOHOL USE? ☐ Yes ☐ No ☐ Former: Year Quit? _____

Type? _____ How much per week? _____

Amount?_____ Last Drink? _____

Advance Directives

☐ None ☐ Do Not Resuscitate ☐ Living Will ☐ Durable Power of Attorney for Health Care

Name of Health Care Proxy: _____