PATIENT HISTORY FORM

Medical History:

Patient Name: ______________________________ DOB: ______

Chief complaint:
What is the main reason for your visit today? (Describe your problem in detail)

Do you now or have you ever had:
Diabetes: ___ Heart murmur: ___ High cholesterol: ___ Crohn's disease: ___ High blood pressure: ___ Heart Failure: ___ Irregular heartbeat: ___ Angina: ___ Abnormal EKG: ___ Heart Attack: ___ Pain in legs while walking: ___ Blood clot in legs: ___ Severe dizziness: ___ Pneumonia: ___ Colitis: ___ Pulmonary embolism: ___ Anemia: ___ Hypothyroidism: ___ Asthma: ___ Jaundice: ___ Goiter: ___ Emphysema: ___ Chronic bronchitis: ___ Hepatitis: ___ Cancer (Type): ________________ Stroke: ___ Stomach or peptic ulcer: ___ Gastrointestinal bleeding: ___ Hemorrhoids: ___ Diverticulosis: ___ Leukemia: ___ Epilepsy(seizures): ___ Rheumatic fever: ___ Psoriasis: ___ Cataracts: ___ Tuberculosis: ___ Kidney disease: ___ HIV/AIDS: ___ Kidney stones: ___ Sleep apnea: Depression: ___ Anxiety: ___

Surgeries/Procedures:

Surgery Approximate date

Allergies:
Allergies: No known Drug Allergies __ Latex: ___ Type of Reaction: _______________

Name of the drug	Reaction you had
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________

<u>Current Medications</u>:
(Include non-prescriptions products)

Medication	Strength	Frequency Taken
________________	________	_________________
________________	________	_________________
________________	________	_________________
________________	________	_________________
________________	________	_________________
________________	________	_________________
________________	________	_________________
________________	________	_________________

<u>Preferred Pharmacy</u>:
Pharmacy Name ________________ Location: ___________________

Are you interested in using UniPlus Health In-Center Pharmacy? Yes __ No __

<u>Social History</u>:
Tobacco: Do you use tobacco? ___ Yes ___ No
Cigarettes ___ Pkts a day, Chew ___ # a day, Pipe ___# a day Cigars ___ # a day ___# of years, or year quit: _____
Alcohol: Do you drink Alcohol? ___ Yes ___ No
If yes, what kind? ________________ How many Drinks per week/day? _________________
Caffeine: Do you drink coffee? ___ Yes ___ No
If yes, how many cups a day? __________________

Do you exercise regularly? Yes/No If yes, how often? ____________

Do you use an e-cigarette? Yes/No If yes, _____ per day, years of use _________

Marihuana / recreational drug use? Yes/No If yes, ___ per day, years of use _____

Family History
List any Family Medical History

PREVENTATIVE SCREENING

Patient Name: _____________________________ DOB: ______

Immunizations:
Tetanus_____ Pneumonia13_____ Pneumonia23_____ Shingles_____ Hepatitis B_____ Hepatitis A_____ Chickenpox_____ Influenza_____ MMR (*Measles, Mumps, Rubella)* _____ HPV _____ COVID-19 ______

- Patient age 50–75: Have you had a colonoscopy? Yes/No If yes, date: _____
- Female patients age 50–74: Have you had a mammogram? Yes/No. If yes, date: _____
- Patients over age 65: Have you fallen in the last 3 months? Yes/No. If yes, how many times? _____
- Patients over age 65: Have you fallen in the last year? Yes/No. If yes, how many times? ____ Were you injured in any of the falls? Yes/No
- If you are diabetic, when was your last A1C? ____/____/____
- Dexa scan over 65 y/o Female? ____/____/____
- Las Eye exam? ____/____/____
  Where was it done? ______________________________________

Women Health:

First Menstrual Cycle: ______________ Days of Menstrual cycle: __________
Last Menstrual Cycle: _______________ Date or Age: ______________
Last PAP Smear: Date: __________ Normal: ____ Abnormal:
Age at Menopause: ____________
Any bleeding after menopause: Yes/No

Any birth control method? ____________________

Pregnancy Summary:

Term: ___
Preterm: ___
Live Children: ___
Miscarriage: ___
C-Section: ___

UniPlus Health

REVIEW OF SYSTEMS

Patient Name: ____________________ Date of birth: __________________

In the past month, have you had any of the following problems?

Constitutional Symptoms
- ☐ Fever
- ☐ Chills
- ☐ Sweating
- ☐ Weakness
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue
- ☐ Trouble sleeping

Cardiovascular
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Swelling of legs

Respiratory
- ☐ Wheezing
- ☐ Cough
- ☐ Dyspnea
- ☐ Sputum
- ☐ Coughing up blood

Skin
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair/nail changes

Eyes
- ☐ Blurry/double vision
- ☐ Redness
- ☐ Pain
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts

Ears
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage

Nose
- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus pain

Throat
- ☐ Gum swelling
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sore throat
- ☐ Dry mouth
- ☐ Non-healing sores
- ☐ Trush
- ☐ Hoarseness

Neck
- ☐ Pain
- ☐ Stiffness
- ☐ Lumps
- ☐ Swollen glands

Breast
- ☐ Pain
- ☐ Lumps
- ☐ Discharge

Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Burping
- ☐ Blood in stool
- ☐ Difficulty swallowing
- ☐ Change in appetite

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Back pain
- ☐ Stiffness
- ☐ Joint swelling
- ☐ Trauma

Endocrine
- ☐ Heat/cold intolerance
- ☐ Thirst
- ☐ Frequent urination
- ☐ Change in appetite

Vascular
- ☐ Leg cramping
- ☐ Calf pain with walking

UniPlus Health

REVIEW OF SYSTEMS

Patient Name: ____________________ Date of birth: __________________

Female Genitourinary

- Frequent urination
- Urgent urination
- Burning or pain
- Vaginal discharge
- Vaginal dryness
- Urine leakage
- Blood in urine
- Lower abdominal pain
- Painful menstruation
- Pain with sex
- Hot flashes

Hematology

- Easy bruising
- Easy bleeding
- Swollen glands
- Blood transfusions
- Anemia
- High cholesterol

Male Genitourinary

- Pain in the testicles
- Penile discharge
- Pain with sex
- Blood in urine
- Nighttime urination
- Frequent urination
- Dribbling of urine
- Difficulty starting urine
- Hernia
- Erectile dysfunction

Psychiatric

- Stress
- Nervousness
- Panic attacks
- Depression
- Memory loss
- Insomnia

Neurologic

- Tremors
- Dizziness
- Fainting
- Headaches
- Weakness
- Numbness
- Tingling
- Seizures
- Memory problems
- Disorientation