RJ KOHN FAMILY MEDICINE, PC

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HEALTH HISTORY INFORMATION

Last Name		First Name	Middle Initial
Sex (Circle One):	Male Female	DOB:	
Physical Address:			Apt:
City	State:	Zip Code:	
Home Phone:	Cell Phone:	Other:	

Past Medical History:

Have you ever had the following?: (*Circle "N" for No or "Y" for Yes. If uncertain leave blank.)*

Measles	Y	N	Anemia	Y	N	Back Trouble	Y	N	Hepatitis	Y	N
Mumps	Y	N	Bladder Infections	Y	N	High Blood Pressure	Y	N	Ulcer	Y	N
Chickenpox	Y	N	Epilepsy	Y	N	Low Blood Pressure	Y	N	Kidney Disease	Y	N
Whooping Cough	Y	N	Migraines	Y	N	Hives or Eczema	Y	N	Thyroid Disease	Y	N
Scarlet Fever	Y	N	Tuberculosis	Y	N	AIDS or HIV+	Y	N	Diphtheria	Y	N
Smallpox	Y	N	Diabetes	Y	N	Infectious Mono	Y	N	Pneumonia	Y	N
Rheumatic fever	Y	N	Cancer	Y	N	Bronchitis	Y	N	Heart Disease	Y	N
Arthritis	Y	N	Polio	Y	N	Stroke	Y	N	Glaucoma	Y	N
Venereal Disease	Y	N	Hernia	Y	N	Other, explain:					

Hospitalizations/Surgeries?		
Year	**Reason**	**Hospital**

List your Prescribed Drugs, Over the Counter Drugs, Vitamins and Inhalers		
Name of Drug	**Strength**	**Frequency**

Marital Status: Single___ Married___ Separated___ Divorced___ Widowed___ Partnership___ Other___
Use of Alcohol: Never___ Rarely___ Moderate___ Daily___
Use of Tobacco: Never___ Previously, but quit___ Current packs/day___
Use of Caffeine: Never___ Soda___ Tea___ Coffee___ Chocolate___
Use of Drugs: Never___ Type/
Frequency_____
Family Medical History: *(be sure to include current age or age of death, major illness history, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)*

Family Member	Age	If Deceased, at what age?	Major illness or chronic conditions:
Father			
Mother			
Siblings			

HEALTH CONCERNS: *(Check off any experienced in the past or present. If unsure, leave blank).*

CONSTITUTIONAL SYMPTOMS			GENITOURINARY			ALLERGIC		
Good general health lately	Y	N	Frequent Urination	Y	N	Penicillin/Other Antibiotics	Y	N
Recent Weight Change	Y	N	Burn/Painful Urination	Y	N	Morphine/Demerol	Y	N
Fever	Y	N	Blood in Urine	Y	N	Other Narcotics	Y	N
Fatigue	Y	N	Change in habits	Y	N	Novocain/Anesthetic	Y	N
			Incontinence	Y	N	Tetanus antitoxin/other serums	Y	N
EYES			Kidney stones	Y	N	Other Drugs/Medications	Y	N
Eye Disease/Injury	Y	N	Sexual difficulty	Y	N	Known Allergies/Food	Y	N
Wear glasses/contacts	Y	N	Male: testicle pain	Y	N			
Blurred/Double Vision	Y	N	Female: Painful periods	Y	N			
			Female: Irregular periods	Y	N			

EARS/NOSE/MOUTH/THROAT		
Hearing loss or ringing	Y	N
Earaches/Drainage	Y	N
Chronic sinusitis	Y	N
Nose Bleeds	Y	N
Mouth Sores	Y	N
Bleeding Gums	Y	N
Bad Breath	Y	N
Sore Throat/Voice Change	Y	N
Swollen Neck Glands	Y	N
Difficulty Swallowing	Y	N

CARDIOVASCULAR		
Heart Trouble	Y	N
Chest pain/Angina	Y	N
Palpitation (flutters)	Y	N
Shortness of Breath	Y	N
Swelling of feet/ankles/ hand	Y	N
High Blood Pressure	Y	N
Chronic/Frequent Cough	Y	N
Cough with Blood	Y	N
TB Exposure	Y	N
Wheezing	Y	N
Asthma	Y	N
Last Chest X-Ray	Y	N

MUSCULOSKELETAL		
Joint Pain	Y	N
Join Stiffness or Swelling	Y	N
Weakness of Muscle or Joint	Y	N

Female:# of pregnancies		
Female: # miscarriages		
Female: Last pap smear		
Sexually active	Y	N
Birth Control	Y	N

INTEGUMENTARY (Skin/Breast)		
Rash/Itching	Y	N
Change Hair/Nails	Y	N
Change in Skin Color	Y	N
Varicose Veins	Y	N
Breast pain	Y	N
Breast lump	Y	N
Breast Discharge	Y	N

PSYCHIATRIC		
Memory Loss/Confusion	Y	N
Nervousness/Anxiety	Y	N
Depression	Y	N
Insomnia	Y	N

HEMATOLOGIC/LYMPHATIC		
Enlarged Glands	Y	N
Slow to Heal Cuts	Y	N
Bleeding/Easy Bruising	Y	N
Anemia	Y	N
Phlebitis/Blood Clots	Y	N
Inflammation of Veins	Y	N
Past Transfusion	Y	N

GASTROINTESTINAL		
Loss of appetite	Y	N
Change in bowel habits	Y	N
Nausea or Vomiting	Y	N
Frequent Diarrhea	Y	N
Painful bowel movement	Y	N
Constipation	Y	N
Abdominal Pain	Y	N
Rectal Bleeding	Y	N
Blood in Stool	Y	N
Hemorrhoids	Y	N

NEUROLOGICAL		
Frequent recurring headaches	Y	N
Lightheaded or Dizzy	Y	N
Convulsions/Seizures	Y	N
Numbness or Tingling	Y	N
Tremors (shaking)	Y	N
Paralysis	Y	N
Head Injury	Y	N
Difficulty Walking	Y	N

IMMUNIZATIONS		
Polio	Y	N
Influenza	Y	N
Tetanus	Y	N
Date of Last Tetanus	Y	N
Hepatitis B	Y	N
Diphtheria	Y	N
Pertussis	Y	N
Rubella	Y	N

Muscle Pain or Cramps	Y	N	**ENDOCRINE**			Measles/Mumps	Y	N
Back Pain	Y	N	Gland/Hormone problem	Y	N	H1N1	Y	N
Cold Extremities	Y	N	Excessive Thirst/ Urination	Y	N	Other	Y	N
Difficulty Walking	Y	N	Heat Cold Intolerance	Y	N			
			Skin Dryness	Y	N			

Tuberculosis (TB) Risk Assessment Questionnaire

1. **Are you from or have you lived for two months or more in Africa, Asia, Central or South America, Or Eastern Europe?** □ No □ Yes If yes, list countries _____

2. **Have you been diagnosed with a chronic condition that may impair your immune system?**

   □ No □Yes If yes, check all that apply

□ chronic steroid use	□ Leukemia, lymphoma or Hodgkin's disease	□ Gastrectomy/intestinal bypass	□ Low body weight (10% or more below ideal)
□ HIV infection	□ Crohn's disease	□ Diabetes mellitus	
□ Cancer of the head or neck	□ Rheumatoid arthritis	□ Dialysis/Renal failure	□ Other
□ Silicosis	□ Chemotherapy	□ Chronic malabsorption syndromes	

3. **Have you ever resided, worked or volunteered in any of the following facilities:**

   □ No □ Yes If yes, check all that apply

□ Prison	□ Hospital	□ Nursing Home	□Homeless Shelter
□ Other long term treatment center			

4. **Do you currently have any of the following symptoms?**

   □ No □ Yes If yes, check all that apply

□ Cough ≥ 3 weeks	□ Unexplained fever	□ Chest pain	□ Chills
□ Productive cough	□ Night sweats	□ Shortness of breath	□ Loss of appetite
□ Coughing up blood	□ Unexplained weight loss	□ Fatigue	□ Weakness

5. **Have you ever had contact with a person known to have active tuberculosis:** □ No □ Yes
6. **Have you ever used injection drugs:** □ No □ Yes
7. **Have you had a tuberculin skin test before:** □ No □ Yes
   If yes, list where given _____ Date _____/___/_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I need.

Signature (parent or guardian if patient is under age 18) **Date**