ELFHP

Patient History Form

Date Completed: _____

Please complete ALL pages, as it will become part of your permanent record.

Male Female

NAME: _____ DOB: _____ Age: _____

Surgical History

Date	Hospitalization/Operation

Medications

Medications/Vitamins/OTC	Dose	Times/Day

Allergies

Medication/Food/Allergies	Reaction/Side Effect

Health Screening	*Normal*	*Date*
Lipid (Cholesterol)	Y N	
Colonscopy/Sigmoidscopy	Y N	
Mammogram	Y N	
Pap Smear	Y N	
Bone Density Scan	Y N	
PSA	Y N	
EKG	Y N	

Social History

Please 'X'	*Yes/NO*	*Amount*
Tobacco	Y N	
Exposure	Y N	
Quit Date:		
What type of tobacco:		
Interesting in quitting?	Y N	-
Alcohol	Y N	
Treatment for alcohol abuse?	Y N	-
Recreational Drugs	Y N	
Prescription Abuse?	Y N	-
What drugs:		
Used Needles?	Y N	-
Treatment for drug abuse?	Y N	-
Caffeine	Y N	
What kind:		
Sexual Activity	-	-
Active?	Y N	
Current partner is/are?	Male	Female
Birth Control Method:	Y N	
Ever had a STD?	Y N	
Safety	-	-
Use seatbelts?	Y N	-
Wear bike helmet?	Y N	-
Have a gun in your home?	Y N	-
Do you feel safe at home?	Y N	-

Socioeconomic
Pediatric/Adol
If child/adol– complete for each parent
Parent Marital Status:
Parent Occupation:
Mother
Father
Foster Child/Adopted Y N
Members of Household:
Tobacco Exposure Y N
Hobbies:
Adult
Occupation:
Employer:
Marital Status:
Spouse/Partner's Name:
Number of Children:
Education- # of yrs completed:
Degree:
Exercise Y N
Type:
Frequency:
Hobbies:

Have you completed a Living Will / Durable Power of Attorney for healthcare:

Y N Name of POA: _____

ELFHP **Patient History Form** Date Completed: _____

Please complete ALL pages, as it will become part of your permanent record. Male Female

NAME: _____ DOB: _____ Age: _____

Condition	*Mother*	*Father*	*Sister*	*Brother*	*Daughter*	*Son*	*Other*
Age of Death/Cause							
ADD/ADHD							
Alcoholism							
Alzheimer's							
Anxiety							
Arthritis							
Asthma							
Bipolar Disorder							
Bleeding Disorder							
Cancer-type:_____							
COPD							
Coronary Artery Disease							
Depression							
Diabetes							
Drug Abuse							
Glaucoma							
Heart Attack							
Heart Disease-type:____							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Migraines							
Obesity							
Osteoporosis							
Prostate Problems							
Seizures							
Stroke							
Thyroid Disorder							
Other							

ELFHP

Patient History Form

Date Completed: _____

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Male Female

NAME: _____ DOB: _____ Age: _____

Please complete for your Personal Health History

ENT	
Frequent Earwax	
Ear Infections-Frequent	
Hearing Loss	
Sinusitis-Frequent	
Strep Throat	
Tinitus(ringing ears)	
OTHER	

Cardiovascular	
Abn. Heart Rhythm	
Carotid Artery Disease	
Congestive Heart Failure	
Coronary Artery Disease	
Blood Clots	
High Cholesterol	
High Blood Pressure	
Heart Attack	
OTHER	

Pulmonary	
Asthma	
Bronchitis-Chronic	
Cough-Chronic	
COPD	
Croup	
Cystic Fibrosis	
Pneumonia	
Pulmonary Embolism	
RSV	
Sleep Apnea	
Tuberculosis	
OTHER	

Gastrointestinal	
Abnormal Liver Function	
Gallbladder Issues	
Cirrhosis	
Colon Polyps	
Crohns's Disease	
Constipation-Chronic	
Diarrhea-Chronic	
Fatty Liver	
Reflux.Heartbum	
Hemorrhoids	
Hepatitis	
Irritable Bowel Syndrome	
Pancreatitis	
Peptic Ulcer	
Colitis	
OTHER	

Renal/Genitourinary	
Kidney Failure	
Enlarged Prostate	
Kidney Problems	
Enuresis	
Erectile Dysfunction	
Infertility	
LUTS	
Prostatitis	
Kidney Stones	
Risky Sexual Behavior	
Urinary Incontinence	
UTI-Recurrent	
OTHER	

Musculoskeletal	
Chronic Pain	
Joint Pain	
Fibromyalgia	
Fracture(s)	
Gout	
Osteoarthritis	
Osteoporosis	
Rheumatioid Arthritis	
Lupus	
TMJ	
Trochanteric Bursitis	
OTHER	

Endocrine	
Addison's Disease	
Cushing's Disease	
Type I Diabetes	
Type II Diabetes	
Hyperthyroidism	
Hypothyroidism	
Metabolic Syndrome	
Testosterone Deficiency	
Thyroid Nodule	
OTHER	

Neurological/Genetic	
Alzheimer's Disease	
Autism	
Carpal Tunnel Syndrome	
Cerebral Palsy	
Stroke/TIA	
Dementia	
Down Syndrome	
Headaches	
Meningitis	
Multiple Sclerosis	
Parkinson's Disease	
Restless Leg Syndrome	
Seizure Disorder	
Traumatic Brain Injury	
Tremor	
Vertigo	
OTHER	

Hematologic	
Anemia	
OTHER	

Allergies/Immunology	
Allergies	
Immunofeficiency	
OTHER	

Dermatology	
Acne	
Chicken pox	
Eczema	
Psoriasis	
Shingles	
OTHER	

Cancer	
Please specify:	

Other Miscellaneous	
Cataract	
Fatigue	
Glaucoma	
Obesity	
Vitamin B12 Deficiency	
Vitamin D Deficiency	
OTHER	

Pyschology	
ADD/ADHD	
Anxiety	
Bipolar	
Conduct Disorder	
Depression	
Eating Disorder	
Insomnia	
Obsessive Compulsive Disorder	
Schizophrenia	
Other	

Newborn History		Pregnancy History	
Full Term	Y N	Prenatal Care	Y N
Birth Wt		Use of Drugs	Y N
Length		Use of Alcohel	Y N
C. Section	Vaginal	Complications	Y N
Complications	Y N	Type:	