

Calhoun Liberty Hospital Primary Care Clinic

20370 NE Burns Ave

Blountstown, FL 32424

Phone: 850-237-3000 Fax: 850-237-3001

**Health History Intake Form**

Your physician today:

🞏 Garrett Chumney, MD Do you have a Living Will? 🞏 Yes 🞏 No

🞏 Teressa Edenfield, ARNP

🞏 Linda Deese, ARNP

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Gender: 🞏 Male 🞏 Female

Previous Primary Care Physician (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Physician’s involved in your care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies-** (*Medication/Food, indicate reaction*): 🞏 None

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication List:** (*Please list name/dose/frequency if known*)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**  (*please indicate deceased or alive, medical issues and age*)

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandparents: Maternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paternal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Calhoun Liberty Hospital Primary Care Clinic Health History Intake Form 1*

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Habits:**

Alcohol: 🞏 None 🞏 Yes: How many drinks/day \_\_\_\_\_\_\_\_\_ frequency/week \_\_\_\_\_\_\_\_\_ what kind \_\_\_\_\_\_

Tobacco: 🞏 None 🞏 Yes: Chew or Smoke? \_\_\_\_\_\_\_\_\_ How many/day \_\_\_\_\_\_\_\_\_\_ since \_\_\_\_\_\_\_\_\_

Caffeine: 🞏 None 🞏 Yes: What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ how many/day \_\_\_\_\_\_\_\_\_\_\_\_

Other recreational drugs: 🞏 None 🞏 Yes: What kind \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many/day \_\_\_\_\_\_\_\_

Do you drive? 🞏 Yes 🞏 No Do you always wear a seatbelt? 🞏 Yes 🞏 No

Do you exercise? 🞏 Yes 🞏 No If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Work: 🞏 Employed 🞏 Unemployed 🞏 Retired 🞏 Disabled

Current Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Former Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: 🞏 Married 🞏 Single 🞏 Divorced 🞏 Domestic Partner

Sexual Preference: 🞏 Men 🞏 Women 🞏 Both

Children (age): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History (indicate date if known)**

🞏 None 🞏 Bariatric Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Cataracts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Hysterectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Lasik \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Endoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Tonsillectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Colonoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Thyroidectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Hernia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Adenoidectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Spinal Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Coronary Bypass \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Tubal Ligation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Cardiac Stents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Bladder Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Pacemaker \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Prostate surgery/resection \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Heart Valve \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 C-Section \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Gall Bladder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Orthopedic/joints \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Appendectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Bowel/Stomach Resection \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Hemorrhoidectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations**  **Immunizations History**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tetanus date: \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Flu date: \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumonia 23 or 13 date: \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical History**

Annual Physical 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_ Physician: \_\_\_\_\_\_\_\_\_\_\_\_

Mammogram 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone Density Scan (Dexa) 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Calhoun Liberty Hospital Primary Care Clinic Health History Intake Form 2*

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History:**

Headaches 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizures 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Type: \_\_\_\_\_\_\_\_ 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Disease Type: \_\_\_\_\_\_\_\_ 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Macular Degeneration 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing Loss 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Clots 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Pulm Emboli (lung clots) 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 DVT (leg clots) 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Burn, Reflux 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stomach Ulcers 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Coronary Disease 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 MI/Heart Attacks 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Congestive Heart Failure 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Atrial Fibrillation 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Angina 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Valve Disorder 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Cholesterol 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastrointestinal Bleeding 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis 🞏A 🞏B 🞏C 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV/AIDS 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Wounds 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer Type: \_\_\_\_\_\_\_\_ 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urinary Tract Infections 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Incontinence 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Stones 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COPD (Emphysema, Bronchitis) 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bipolar Disorder 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fibromyalgia 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Fatigue Syndrome 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gout 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Osteoporosis 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prostate Disease 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Disease 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Erectile Dysfunction 🞏 Yes 🞏 No date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Calhoun Liberty Hospital Primary Care Clinic Health History Intake Form 3*

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems ( ✓ Yes or No for symptoms in past 6 months, Circle for symptoms TODAY)**

**Constitutional/Endocrine**  **FEMALE Reproductive**
🞏 Yes 🞏 No Fever 🞏 Yes 🞏 No Hot flashes

🞏 Yes 🞏 No Chills 🞏 Yes 🞏 No Bleeding after menopause

🞏 Yes 🞏 No Weakness/Fatigue 🞏 Yes 🞏 No Excessive menstrual bleeding

🞏 Yes 🞏 No Weight Loss 🞏 Yes 🞏 No Unusual vaginal discharge

🞏 Yes 🞏 No Weight Gain Age at onset of menstruation \_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Yes 🞏 No Insomnia 1st day of last menstruation \_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Yes 🞏 No Snoring 🞏 Yes 🞏 No Menstrual pain/cramps

🞏 Yes 🞏 No Excessive thirst 🞏 Yes 🞏 No Spotting between periods

🞏 Yes 🞏 No Excessive urination Last PAP smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Results:\_\_\_\_\_\_\_\_\_\_\_

🞏 Yes 🞏 No Cold or Heat intolerance History of Abnormal PAP? 🞏 Yes 🞏 No if so, when \_\_\_\_\_\_\_\_

 Total Pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEENT**

🞏 Yes 🞏 No Sore Throat

🞏 Yes 🞏 No Stiff neck

🞏 Yes 🞏 No Change in your voice **Cardiac**

🞏 Yes 🞏 No Sinus Drainage 🞏 Yes 🞏 No Chest Pain

🞏 Yes 🞏 No Sinus headache 🞏 Yes 🞏 No Palpitation

🞏 Yes 🞏 No Nose Bleeds 🞏 Yes 🞏 No Irregular heartbeat

🞏 Yes 🞏 No Ear ache/drainage 🞏 Yes 🞏 No Exercise intolerance

🞏 Yes 🞏 No Hearing Loss 🞏 Yes 🞏 No Leg Swelling

🞏 Yes 🞏 No ringing in your ears Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Yes 🞏 No Blurred Vision/loss

🞏 Yes 🞏 No Wear glasses/contacts **Respiratory**

🞏 Yes 🞏 No Itchy/watery eyes 🞏 Yes 🞏 No Persistent Cough

🞏 Yes 🞏 No Dental problems 🞏 Yes 🞏 No Coughing up blood

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Yes 🞏 No Wheezing

 🞏 Yes 🞏 No Can’t breathe laying flat

**Gastrointestional**  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Yes 🞏 No Nausea/vomiting

🞏 Yes 🞏 No Difficulty swallowing **Skin**

🞏 Yes 🞏 No Hemorrhoids 🞏 Yes 🞏 No Rashes/Hives

🞏 Yes 🞏 No Diarrhea 🞏 Yes 🞏 No Skin discoloration

🞏 Yes 🞏 No Constipation 🞏 Yes 🞏 No Lesions/moles/warts

🞏 Yes 🞏 No Bloody or Black Stools 🞏 Yes 🞏 No Ulcers

🞏 Yes 🞏 No Abdominal pain 🞏 Yes 🞏 No Itching

🞏 Yes 🞏 No Heart burn/indigestion 🞏 Yes 🞏 No Nail Problem

🞏 Yes 🞏 No Frequent use of laxatives 🞏 Yes 🞏 No Unusual hair loss

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Yes 🞏 No easy bruising

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Urinary**

🞏 Yes 🞏 No Pain or burning with urination **Psych**

🞏 Yes 🞏 No Urinary frequency (Night or Day) 🞏 Yes 🞏 No Depressed mood

🞏 Yes 🞏 No Blood in urine/ dark urine 🞏 Yes 🞏 No Suicidal thoughts/plans

🞏 Yes 🞏 No Incontinence 🞏 Yes 🞏 No Agitation/Irritability

🞏 Yes 🞏 No Slow starting or stopping urine 🞏 Yes 🞏 No Insomnia

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Yes 🞏 No Anxiety

 🞏 Yes 🞏 No Frequent crying spells

**Genital/Sex Organs**  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Yes 🞏 No Penile Discharge

🞏 Yes 🞏 No Testicular lump/pain **Neurologic**

🞏 Yes 🞏 No Breast Pain/discharge/Lump 🞏 Yes 🞏 No Frequent headaches

🞏 Yes 🞏 No Painful intercourse 🞏 Yes 🞏 No Seizures

🞏 Yes 🞏 No Lack of sexual desire 🞏 Yes 🞏 No Syncope (passing out)

🞏 Yes 🞏 No Problems with performance 🞏 Yes 🞏 No Limb weakness

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Yes 🞏 No Limb numbness

 🞏 Yes 🞏 No Dizziness

**Musculoskeletal** 🞏 Yes 🞏 No Difficulty Swallowing

🞏 Yes 🞏 No Joint pains/stiffness 🞏 Yes 🞏 No Balance issues

🞏 Yes 🞏 No joint swelling 🞏 Yes 🞏 No Tremors

🞏 Yes 🞏 No Muscle weakness 🞏 Yes 🞏 No Rigidity

🞏 Yes 🞏 No Back pain 🞏 Yes 🞏 No History of Falls

🞏 Yes 🞏 No Muscle spasms/cramps Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Yes 🞏 No falling

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Calhoun Liberty Hospital Primary Care Clinic Health History Intake Form 4*