

Benson Health Clinic
Health History/Review of Systems

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Occupation: _____

PCP: _____ Other Providers I see: _____

General Health (circle): Excellent Good Fair Poor

Reason for Seeking Medical Attention: _____

Review of Systems: **check** any of the following symptoms you have experienced in the **past year**.

<p style="text-align: center;"><u>Constitutional</u></p> <ul style="list-style-type: none"> <input type="radio"/> Chills <input type="radio"/> Fever <input type="radio"/> Weight Gain <input type="radio"/> Weight Loss 	<p style="text-align: center;"><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="radio"/> Chest Pain <input type="radio"/> Poor Circulation <input type="radio"/> Swelling legs <input type="radio"/> Palpitations <input type="radio"/> Irregular heart rhythm <input type="radio"/> Other _____ 	<p style="text-align: center;"><u>Reproductive</u></p> <ul style="list-style-type: none"> <input type="radio"/> Painful Periods <input type="radio"/> Painful Sex <input type="radio"/> Vaginal discharge <input type="radio"/> Breast discharge <input type="radio"/> Breast lump 	<p style="text-align: center;"><u>Neurological</u></p> <ul style="list-style-type: none"> <input type="radio"/> Dizziness <input type="radio"/> Leg/arm numbness <input type="radio"/> Leg/arm weakness <input type="radio"/> Problems with walking <input type="radio"/> Headache <input type="radio"/> Memory loss <input type="radio"/> Seizures <input type="radio"/> Tremors <input type="radio"/> Other 	<p style="text-align: center;"><u>Musculoskeletal</u></p> <ul style="list-style-type: none"> <input type="radio"/> Back pain <input type="radio"/> Joint pain <input type="radio"/> Joint swelling <input type="radio"/> Muscle weakness <input type="radio"/> Neck pain <input type="radio"/> Other _____
<p style="text-align: center;"><u>HEENT</u></p> <ul style="list-style-type: none"> <input type="radio"/> Hearing loss <input type="radio"/> Pain in the head <input type="radio"/> Nasal drainage <input type="radio"/> Visual changes <input type="radio"/> Allergy symptoms <input type="radio"/> Head cold 	<p style="text-align: center;"><u>Gastrointestinal</u></p> <ul style="list-style-type: none"> <input type="radio"/> Stomach pain <input type="radio"/> Blood in stool <input type="radio"/> Change in stool <input type="radio"/> Constipation <input type="radio"/> Diarrhea <input type="radio"/> Heartburn <input type="radio"/> Change of appetite <input type="radio"/> Nausea <input type="radio"/> Vomiting <input type="radio"/> Other _____ 	<p style="text-align: center;"><u>Integumentary</u> (skin, hair, nails)</p> <ul style="list-style-type: none"> <input type="radio"/> Hair loss <input type="radio"/> Abnormal hair growth <input type="radio"/> Hives <input type="radio"/> Itchiness <input type="radio"/> Rash <input type="radio"/> Skin lesion <input type="radio"/> Other _____ 	<p style="text-align: center;"><u>Psychiatric</u></p> <ul style="list-style-type: none"> <input type="radio"/> Anxiety <input type="radio"/> Depression <input type="radio"/> Trouble sleeping <input type="radio"/> Other _____ 	<p style="text-align: center;"><u>Hematologic/ Lymphatic</u></p> <ul style="list-style-type: none"> <input type="radio"/> Easy bleeding <input type="radio"/> Easy bruising <input type="radio"/> Swollen lymph nodes <input type="radio"/> Other _____
<p style="text-align: center;"><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="radio"/> Cough <input type="radio"/> Shortness of breath <input type="radio"/> Wheezing <input type="radio"/> Other _____ 	<p style="text-align: center;"><u>Genitourinary</u></p> <ul style="list-style-type: none"> <input type="radio"/> Burning with urination <input type="radio"/> Blood in urine <input type="radio"/> Lots of urine <input type="radio"/> Frequent urination <input type="radio"/> Urinary incontinence <input type="radio"/> Urinary retention 	<p style="text-align: center;"><u>Metabolic/ Endocrine</u></p> <ul style="list-style-type: none"> <input type="radio"/> Cold intolerance <input type="radio"/> Heat intolerance <input type="radio"/> Always thirsty <input type="radio"/> Always hungry <input type="radio"/> Other _____ 	<p style="text-align: center;"><u>Immunologic</u></p> <ul style="list-style-type: none"> <input type="radio"/> Contact allergy <input type="radio"/> Environmental allergy <input type="radio"/> Food allergy <input type="radio"/> Seasonal allergy <input type="radio"/> Frequently getting sick <input type="radio"/> Other _____ 	<p style="text-align: center;"><u>Other</u></p> <ul style="list-style-type: none"> <input type="radio"/> Traveled outside USA? <input type="radio"/> Seen a Specialist MD? <input type="radio"/> Had any hospitalizations, surgery or been to Urgent Care?

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Personal History (please circle and date those **YOU** have had)

	<u>Date:</u>		<u>Date:</u>
AIDS/HIV Positive:		Hernia	
Anemia		High Blood Pressure	
Angina/Heart Pain		Kidney Disease or Stones	
Arthritis or Rheumatism		Liver Disease	
Asthma or Hay Fever		Lung Disease	
Bladder or Prostate Trouble		Mental Illness	
Blood Transfusion		Migraine Headache	
Bone Disease		Paralysis	
Cancer:		Pneumonia	
Cholesterol/Triglyceride Problem		Polio	
Chronic Bronchitis		Polyps, Colon	
Colitis or Bowel Disease		Phlebitis (Clot)	
Diabetes		Scarlett Fever	
Eating Disorder		Seizures/Convulsions	
Emotional Disorder		Skin Trouble/Disease	
Eye Disease or Glaucoma		Stroke	
Gall Bladder Disease		Thyroid Disease	
Gout		Tonsils Removed (Age)	
Heart Disease		Tuberculosis	
Head Injury		Ulcers	
Hepatitis:		Urinary Tract Infection	
Other:			

Measles: _____ Mumps: _____ Rubella: _____

Chicken Pox: _____ Rheumatic Fever: _____

Other: _____

Preventative Care/Immunizations History (please date those you have had with the most current)

Diphtheria/Pertussis Tetanus: _____ Flu: _____ Pneumonia: _____

Gardasil Vaccine (HPV): _____ Shingles: _____ Meningitis: _____

Colonoscopy: _____ Pap: _____ Bone Density: _____ Mammogram: _____

Female Health History

Age of 1st period: _____ 1st day of last period: _____ Age periods stopped: _____

Currently pregnant: Y / N # of pregnancies: _____ # of live births: _____

Method of Birth Control: _____ Have you ever had an STD? _____

Have you ever had an abnormal pap: Y / N Date: _____ # of sex partners in past year? _____

Do you have history of: Endometriosis Ovarian Growths Fibroids DES exposure Infertility

Decrease or increase in sexual desire? Y / N Sexual Orientation: G L B T Q Hetero

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Medicines: (include Non-Prescription Drugs, Herbs and Vitamins)

Current Medication	Size/Dose	How you take
Allergies (medicine/food/etc.)	What was your reaction?	

Social: Have you participated in the following?

Alcohol	No	Yes	How Often/Much:	
Tobacco	No	Yes	How many per day:	Quit Date:
Illicit Drugs	No	Yes	How Often:	Quit Date:
Caffeine	No	Yes	How Often/Much:	
Energy Drinks	No	Yes	How Often:	
Regular Exercise	No	Yes	Minutes:	How many times per week:
Weight:	Current:		1 year ago:	5 years ago:

Are there any cultural or personal beliefs that you would like me to know about?

Are you currently or have you ever been in a relationship where you were hurt, threatened or made to feel afraid? Yes / No

Who do you live with? _____ House / Apartment / Other: _____

List any previous Hospitalizations, Chronic Illness, Surgeries, Injuries or Accidents

(List cause or type, include Psychiatric but omit pregnancies)	<u>Year</u>

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Family History	Age	Health	Age @ Death	Cause	Has any blood relative ever had: (if yes, indicate relation and age of onset)
Father					Allergy/Asthma
Mother					Arthritis/Gout
Siblings: (m/f)					Bleeding Disorder
1					Clotting Disorder
2					Cancer
3					Colon Polyp
4					Depression
5					Diabetes
					Epilepsy/Seizures
Spouse					Glaucoma
Children: (m/f)					Heart Disease
1					Coronary Artery Disease
2					High Blood Pressure
3					Liver Disease
4					Kidney Disease
5					Mental Illness
					Alcohol/Substance Abuse
					Migraines
					Overweight
					High Cholesterol
					Stroke
					Thyroid Disease
					Osteoporosis
					Endometriosis
					Hysterectomy
					Ovarian Cysts

Prevention/Wellness

Would you like help with:

Weight Loss? Yes / No

Stopping Tobacco Use? Yes / No

An Exercise Program? Yes / No

Immunizations? Yes / No

Food and/or housing? Yes / No

Other: _____

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