WESTERN WISCONSIN MEDICAL ASSOCIATES

PATIENT HEALTH HISTORY

DATE COMPLETED

NAME	AGE	DOB

OCCUPATION	SIGNIFICANT OTHER

Please indicate if you currently or recurrently have any of the following:

SYSTEM REVIEW:

General	YES	NO
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Chills	☐	☐
Fatigue	☐	☐

Eyes	YES	NO
Wear Glasses	☐	☐
Wear Contacts	☐	☐
Vision Change	☐	☐
Last Eye Exam ________________		
Eye Pain	☐	☐
Double Vision	☐	☐

Ears, Nose, Throat, Mouth	YES	NO
Ringing in Ears	☐	☐
Decreased Hearing	☐	☐
Ear Pain	☐	☐
Runny Nose	☐	☐
Sneezing	☐	☐
Sinus Infections	☐	☐
Nose Bleeds	☐	☐
Sore Throat	☐	☐
Tooth Pain	☐	☐
Last Dental Exam ______________		
Voice Change	☐	☐

Cardiovascular	YES	NO
Chest Pain	☐	☐
Heart Fluttering	☐	☐
Difficulty Lying Flat	☐	☐
Heart Murmur	☐	☐
Rheumatic Fever	☐	☐
High Blood Pressure	☐	☐
Swelling In Legs	☐	☐
Loss Of Consciousness	☐	☐

Respiratory	YES	NO
Cough	☐	☐
Short Of Breath	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Exposure To TB	☐	☐

Gastrointestinal	YES	NO
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐
Heartburn	☐	☐
Blood In Stools	☐	☐
Black/tarry Stool	☐	☐
Constipation	☐	☐
Ulcer Disease	☐	☐

Urologic / Gynecologic	YES	NO
Pain With Urination	☐	☐
Frequent Urination	☐	☐
Increased Urge To Urinate	☐	☐
Difficulty Urinating	☐	☐
Up At Night Urinating	☐	☐
Losing Urine Control	☐	☐
Sexually Transmitted Diseases	☐	☐
Males:		
Difficulty With Erection	☐	☐
Females:		
Age Of First Menses __________		
Regular Menses	☐	☐
Menstrual Duration ________ Days		
Cycle Interval ____________ Days		
Last Menses Started __________		
Abnormal Pap Smear	☐	☐

Musculoskeletal	YES	NO
Joint / Muscle Pain	☐	☐
Joint / Muscle Weakness	☐	☐
Recent Injuries / Falls	☐	☐

Skin	YES	NO
Changing Moles	☐	☐
Skin Cancer	☐	☐

Neurologic	YES	NO
Headaches	☐	☐
Numbness / Tingling	☐	☐
Memory Changes	☐	☐

Endocrine	YES	NO
Intolerance To Heat	☐	☐
Intolerance To Cold	☐	☐
Excessive Hunger	☐	☐

Hematologic	YES	NO
Anemia	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Prior Blood Transfusion	☐	☐

Allergic / Immunologic	YES	NO
Seasonal Allergies	☐	☐
Recurrent Infections	☐	☐
Chicken Pox Disease	☐	☐
Chicken Pox Vaccine	☐	☐
Last Tetanus Booster ___________		
Last Pneumonia Vaccine _________		

Social / Family	YES	NO
History Of Abuse	☐	☐

Present Concerns: ________________________________

Current Medical Conditions: ________________________________

Previous Hospitalizations: ________________________________

Previous Surgeries: ________________________________

Allergies: ________________________________

Current Medications: ________________________________

OBSTETRIC HISTORY: (Fill in as appropriate)

Pregnancy Date(s)	Outcome (i.e. Vaginal Birth)

SEXUAL HISTORY: (Circle answers and fill in as appropriate)

Are you sexually active? YES NO NOT CURRENTLY

Sexual Partners: MALE(S) FEMALE(S) BOTH

Method of Contraception: ________________

HABITS: (Circle answers and fill in as appropriate)

Tobacco? YES QUIT NEVER

SMOKE CHEW SNUFF

Amount Per Day ________________

Years Spent ________________

Alcohol? YES QUIT NEVER

Times per week ________________

Amount per time ________________

Ever felt like you ought to cut down? YES NO

Have people annoyed you by criticizing your drinking? YES NO

Have you felt guilty about your drinking? YES NO

Have you ever had an ‘eye-opener’ morning drink? YES NO

Other Drugs? YES QUIT NEVER

(i.e. Marijuana) Which drugs? ________________

Do you exercise regularly? YES NO

Which exercises? ________________

How many times per week? ________________

Do you follow a special diet? YES NO

Know your cholesterol levels? YES NO

Total ______ HDL ______ LDL ______ Triglyceride ______

Wear seat belts?	YES	NO	SOME
Wear a bike helmet?	YES	NO	SOME
Have a smoke detector?	YES	NO	
Carbon monoxide detector?	YES	NO	
Adult / infant CPR training?	YES	NO	
If you own a gun, is it secured?	YES	NO	N / A
(Women) Self Breast Exam?	YES	NO	
(Women) Screening Mammogram?	YES	NO	
(Men) Self Testicular Exam?	YES	NO	

FAMILY: (Circle answers and fill in as appropriate)

	LIVING	AGE	HEALTH CONDITIONS
MOTHER ______	Y N		
FATHER ______	Y N		
SIBLINGS			
1. M ______ F ______	Y N		
2. M ______ F ______	Y N		
3. M ______ F ______	Y N		
4. M ______ F ______	Y N		
5. M ______ F ______	Y N		
6. M ______ F ______	Y N		
CHILDREN (List names of children)			
1 ______	Y N		
2 ______	Y N		
3 ______	Y N		
4 ______	Y N		
5 ______	Y N		