REEDSBURG AREA MEDICAL CENTER
PATIENT HEALTH HISTORY

PATIENT HEALTH HISTORY:
The following background information will be used to best determine the safest treatment options to restore your highest functional level. All information is considered confidential and will become part of your permanent medical record. If you do not understand a particular question, please leave it blank. Thank you!

Name:_________________________________ Leisure Activities:_________________________________

Occupation:_________________________________ Full Time / Part Time/ Not Employed (circle one)

Where would you like to receive appointment reminders? (please check **ONE**)

☐ E-mail address:_________________________________

☐ Text message to the following cell number:_________________________________

☐ Automated phone call to my cell or home phone:_________________________________:

☐ None of the above. I will remember my appointments on my own.

Please list any **ALLERGIES**:_________________________________
Right handed / Left handed (circle one)
Any customs or religious beliefs or wishes that might affect care?_________________________________
Do you have any trouble: Seeing Reading Hearing (circle all that apply)
How do you learn best: Seeing Doing Hearing Demonstration (circle all that apply)

Please check any of the following whose care you are under:

____Medical Doctor	____Psychiatrist/Psychologist	____Physical Therapist
____Osteopath	____Chiropractor	____Occupational Therapist
____Dentist	____Home Health	Other____________________

*If you have seen any of the above, during the past year, please describe for what reason (illness, medical condition, physical, etc)
____
____

Have you recently noticed any of the following: (please circle yes or no)

YES	NO	Unexplained weight loss/gain	YES	NO	Rash or skin changes
YES	NO	Nausea/vomiting	YES	NO	Difficulty swallowing
YES	NO	Dizziness/lightheadedness	YES	NO	Memory loss
YES	NO	Fatigue	YES	NO	Cough
YES	NO	Weakness	YES	NO	Shortness of breath
YES	NO	Fever/chills/sweats	YES	NO	Disturbed sleep
YES	NO	Numbness/tingling	YES	NO	Infection

YES	NO	Changes in bowel/bladder function (constipation, diarrhea, increase urgency/frequency)

(PLEASE COMPLETE OTHER SIDE)

Have you ever been diagnosed with any of the following conditions? (please circle yes or no)

YES	NO	Heart trouble	YES	NO	Dizziness
YES	NO	Pacemaker placement	YES	NO	High Blood Pressure
YES	NO	Blood Clot	YES	NO	Diabetes
YES	NO	Cancer	YES	NO	Thyroid Problems
YES	NO	Impaired Sensation	YES	NO	Drug/Alcohol Problem
YES	NO	Asthma	YES	NO	Rheumatoid Arthritis
YES	NO	Emphysema/Bronchitis	YES	NO	Osteoarthritis
YES	NO	Lung Disease	YES	NO	Epilepsy/Seizures
YES	NO	Stroke/TIA	YES	NO	Depression
YES	NO	Chronic UTI	YES	NO	Osteoporosis
YES	NO	Multiple Sclerosis	YES	NO	Circulation Problems
YES	NO	Hepatitis	YES	NO	Tuberculosis
YES	NO	Kidney Disease	YES	NO	Anemia

Please list any surgeries or other conditions for which you have been hospitalized, and any injuries for which you have been treated, including the approximate dates:

1.____ 3.____

2.____ 4.____

Which of the following OVER-THE-COUNTER medication have you taken in the last week: (please circle yes/ no)

YES	NO	Aspirin	YES	NO	Tylenol
YES	NO	Advil/Motrin/Ibuprofen	YES	NO	Laxatives
YES	NO	Decongestants	YES	NO	Antihistamines
YES	NO	Antacids	YES	NO	Vitamins/mineral supplements

YES NO Other, include any herbal remedies____

YES NO Do you use chewing tobacoo?

YES	NO	Do you smoke? If yes, how many packs per day?________________________________
YES	NO	Do you drink alcohol? If yes, how many drinks per week?________________________
YES	NO	Do you drink caffeinated beverages? If yes, how many drinks per day?_____________
YES	NO	Do you exercise beyond normal daily activities or chores? If yes, what is the activity? ______________________________________How many minutes per day?__________ How many days per week?____
YES	NO	During the past month have you been feeling down, depressed, or hopeless?
YES	NO	During the past month have you been bothered by having little interest or pleasure in doing things?
YES	NO	Do you ever feel unsafe in your home or has anyone hit you or tried to injure you in any way?
YES	NO	If you are a woman, are you currently pregnant?

I certify, by my signature, that the foregoing information I have given is accurate and truthful to the best of my knowledge.

____ ________________________________

Patient Signature Date