Georgia Infectious Diseases, P.C.

HEALTH HISTORY

PATIENT NAME_____ DOB____/____/_____ AGE_____

REASON FOR VISIT/CHIEF COMPLAINT_____

Preferred Pharmacy: _____ Referral Physicians: _____

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY.

1. VITALS: Height: ____ft ____in Weight: ____lbs (Staff use: Temp: ____RR:____ Pulse: ___)

2. **PAST MEDICAL HISTORY** – Have you ever had the following: ____**Patient denies any PMH**

	DATES		DATES		DATES
Adrenal Dysfunction		Eclampsia		IB Dis		Pulmonary Fibrosis	
Alzheimer		Endocarditis		IHR		Re-Infections	
Amyotrophic Sclerosis		Endometriosis		Kyphosis		Restless leg Synd.	
Anorexia		End Stage Renal		Liver Dys.		Sarcoidosis	
Arteriovenous		Erectile		Kidney Dys.		Schizophrenia	
Arthritis		Esophageal Dis.		Malignancy		Scleroderma	
Asthma		Fibromyalgia		Mania		Scoliosis	
Bleeding Dis		Gallstone		Muscular Dys		Seizure Dis.	
Cataracts		Gastritis		Narcolepsy		Sickle Cell	
Cerebrovascular		GERD		Ob sleep Apnea		Sjogren's	
Claudication		Glaucoma		Organ Tranpl		Skin Dis.	
Clotting Dis		Heart Val Def		Osteoporosis		Thalassemia	
Congenital Heart def.		Hemochromatosis		Pancreatitis		Thrombocytopenia	
Coronary Artery Dis		Hepatitis		PLM Dis.		Transfusions	
COPD		HIV/AIDs		Peripheral Artery Dis		Tuberculosis	
Cystic Fibrosis		Hypertension		Personality Dis.		Urinary Retention	
Depression		Hyperthyroidism		Pituitary Dys.		Vasculitis	
Diabetes		Hypotension		Polycystic Syn		Visual Defects	
Dialysis		Hypothyroidism		Pulmonary Artery		Vocal Cord Dys.	
Other		Other		Other		Other	

3. **PAST SURGICAL HISTORY** – Have you ever had the following: _____ **Patient denies any surgeries**

	DATES		DATES		DATES
Lung Biopsy		Appendix		ICD (I C Defibrillator)	
Hernia		Heart Bypass		Stent	
Gallbladder		Stomach		Cardiac Cath	
Tonsil /Adnoids		Heart Value Rep		Angioplasty	
Hysterectomy		Other		Pacemaker Insertion	
Other				Other	

4. **MEDICATIONS**: Please list all medicines you are currently taking (Please continue on back of sheet if you need more space)

_____ **Patient denies taking any Medications**

Current Medications:	Dosage (mg)	How often per day?

(OVER)

5. **ALLERGIES:** Please List: (food, drugs, and environment) _____ **Patient denies any Allergies**

_____ _____

_____ _____

_____ _____

6. **FAMILY HISTORY:** Has any blood relative had any of the following: (Check box, leave blank if uncertain)

_____ **Patient denies family history**

		Type	Relationship to you
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
MI/Heart Disease	_____	_____	_____
Seizure Disorder	_____	_____	_____
High Blood Pressure	_____	_____	_____
Stroke	_____	_____	_____
Kidney Dis/Dialysis	_____	_____	_____

7. **SOCIAL HISTORY:**

Marital Status: Single ☐ Married ☐ Divorced ☐

Physical Activity: ☐ very active ☐ somewhat active ☐ not active

Occupation: _____ ☐ Active ☐ not working ☐ retired ☐ Disability

Alcohol: ☐ None ☐ Rarely ☐ Occasionally ☐ Daily If yes, amount per day _____

Tobacco ☐ None ☐ Rarely ☐ Occasionally ☐ Daily If yes, pack per day____ If quit when _____

Drugs: ☐ None ☐ Rarely ☐ Occasionally ☐ Daily If yes, type/frequency _____

Excessive Exposure at home/work to: ☐ fumes ☐ dust ☐ chemicals ☐ asbestos ☐ other _____