MUNSON HEALTHCARE
OMH Medical Group – Gaylord
A Service of Otsego Memorial Hospital

Health History Today's Date:_____

Please answer the questions below. This information will be kept confidential and used for your continuing care.

Name: _____ DOB: _____ Handedness:

Primary Care Physician: _____ Right _____

Referring Physician: _____ Left _____

Date of Last Physical Exam: _____ Height: _____ Weight: _____

Date of Last Eye Exam/Doctor: _____ Last Dental Exam/Dentist: _____

Preferred Pharmacy: _____

Personal History

Please check and ***list date or age*** if you have ever had any of the problems listed below.

Problem	*Date/Age*
__ A-Fib/Atrial Fibrillation	
__ Aids or HIV+	
__ Alcoholism	
__ Alzheimer's	
__ Anemia	
__ Aneurysm/ location:	
__ Anorexia __ Bulimia	
__ Arthritis/Rheumatism	
__ Asthma	
__ Back Trouble	
__ Bladder Infections	
__ Broken Bones/Recurrent Dislocations	
__ Bronchitis/Pneumonia	
__ Blood or Plasma Transfusions	
__ Bursitis	
__ Cancer/*Type*	
__ Cataracts	
__ Chemical Dependency	
__ Chicken Pox	
__ Colitis/Bowel Problems	
__ Concussions/Head Injury	
__ Convulsions/Seizures	
__ Diabetes	
__ Depression/Mental Illness	

Problem	*Date/Age*
__ Dementia	
__ Emphysema __ COPD	
__ Eye Disease	
__ GERD/Gastro Refluxe	
__ Gall Bladder Disease	
__ Glaucoma	
__ Goiter	
__ Gout	
__ Heart Attack	
__ Heart Disease	
__ Heart Valve Problem	
__ Hepatitis/Jaundice	
__ Hemorrhoids	
__ Hernia	
__ Herpes	
__ High/Low Blood Pressure	
__ High Cholesterol	
__ Hypoglycemia	
__ Kidney Disease	
__ Liver Disease	
__ Measles	
__ Meningitis	
__ Migraine Headaches	
__ Mumps	
__ Obesity	

Problem	*Date/Age*
__ Pacemaker	
__ Phlebitis	
__ Defibrillator	
__ Deep Vein Thrombosis	
__ Pleurisy	
__ Polio	
__ Prostate Problems	
__ Psoriasis	
__ Psychiatric Care	
__ Rheumatic Fever	
__ Sciatica	
__ Sexually Transmitted Disease	
__ Sleep Apnea	
__ Stomach Trouble	
__ Strep Throat	
__ Stroke	
__ Thyroid Problems	
__ Tonsillitis	
__ Tuberculosis	
__ Positive TB Test	
__ Ulcers	
__ Varicose Veins	
__ Whooping Cough	
__ Other _____	

Social History

How often do you:

Exercise _____ *Drink:* Alcohol _____ Caffeine _____

Use Tobacco: Cigarettes ____packs per day for ___ years Cigars ___ per day for ___ years

Chew ___ Snuff ___ Exposed to secondhand smoke ___ yes ___ no

Use Marijuana: _____yes _____no If yes, are you Medical Marijuana card holder: _____yes _____no

Use street drugs: _____

Your occupation: _____ Marital status: _____ Children_____

Reviewed by: _____ **on** _____

Provider Date

Name: _____ DOB: _____

Surgery

Have you had removed: Have you had problems with anesthesia? ____*Yes* _____*No*

__ Tonsils __ Adenoids __ Tubes in Ears/***Date :*** ____ __ Hernia Repair __ Gall Bladder

__ Vasectomy __ Appendix __ Colonoscopy/***Date*** :_____ __ EGD/***Date*** :_____ __ Hemorrhoids

__ C-Section __ Tubal Ligation __ Fallopian Tubes __ Ovaries __ Uterus

Orthopedic Procedures (bone/joint)

__ Arthroscopy (what joint(s)): _____ __ Joint Replacement

__ Other_____ *Type/When* : _____

__ Other_____ *Type/When* : _____

Cardiovascular Procedures (heart/blood vessels)

__ Catheterization __ Open heart surgery __ Valve Replacement

__ Stents/type (please have stent card available) __ Vascular Graft (for example, bypass surgery)

__Renal __Cardiac __Vascular *Type/When* : _____

Other Operations_____

Family History: Please fill in the health information about your immediate family

	Age/Health Status	List any Health Conditions	If Deceased	
			Cause of Death	Date
Father				
Mother				
Brother				
Sister				

Have you recently had any of the following:

__ Abdominal pain __ Change in stool size __ Exposure to pets

__ Weight Loss __ Blood in stool __ Valve disease requiring antibiotics

__ Change in bowel habits __ Family history of colon cancer or polyps __ Blood thinner

Women:

__ Abnormal Pap Smear

__ Breast lump, pain, or discharge

__ Menstrual pain or cramps

Age Periods Began _____

No. of Days Flow _____

Date of last menstrual period _____

Date of last Pap Smear _____

Date of last Mammogram _____

Where? _____

__ Menopause/***Date*** _____

No. of Pregancies _____

No. of Deliveries _____

No. of Miscarriages _____

No. of Abortions _____

Men:

__ Breast lump

__ Breast lump, pain, or discharge

__ Erection difficulties

__ Testicle pain or swelling

__ Sore on penis or discharge

__ Problem with urination

Allergies: Include food, drug, and environmental allergies

Allergies:	Reaction:	Are you allergic to **Latex?** _____*Yes* _____*No*
		Are you allergic to **Iodine - CT dye - MRI dye**? _____*Yes* _____*No*
		Are you allergic to or have sensitivities to **Metals?** _____*Yes* _____*No*

Reviewed by: _____ **on** _____

Provider Date

Name: _____ DOB: _____ Today's Date: _____

Medications: Please list all medications you are currently taking including all over-the-counter and vitamins and/or supplements.

Medication Name	Strength	How many/How often?	Reason for taking

Please check if you have recently experienced any of the following:

Systemic Symptoms
__ Weight Change
__ Chills
__ Fever
__ Feeling tired or poorly
__ Other
__ Hot flashes

Head Symptoms
__ Headache
__ Facial Pain __ Sinus Pain
__ Other Head-related Symptoms

Eye Symptoms
__ Eyesight Problems
__ Photophobia
__ Eye pain
__ Itching of the eyes
__ Other Eye Symptoms

Ears/Nose/Throat
__ Earache
__ Hearing Loss
__ Ringing in the Ears
__ Nosebleeds
__ Nasal Discharge
__ Mouth Sores
__ Bleeding Gums
__ Hoarseness
__ Throat Pain
__ Other Symptoms

Neck Symptoms
__ Neck Pain
__ Neck Stiffness
__ Lump or Swelling in Neck
__ Other Neck Systems

Cardiovascular
__ Chest pain or discomfort
__ Fast Heart Rate
__ Palpitations
__ Other Cardiovascular Symptoms

Pulmonary Symptoms
__ Shortness of Breath
__ Cough
__ Coughing up blood
__ Night Sweats
__ Wheezing
__ Other Pulmonary Symptoms

Gastrointestinal Symptoms
__ Appetite Problems
__ Difficulty Swallowing
__ Heartburn
__ Nausea
__ Vomiting
__ Abdominal Pain
__ Diarrhea
__ Black or Bloody Stools
__ Other Gastrointestinal Symptoms
__ Constipation

Genital or Urinary
__ Painful or difficult urination
__ Increased Frequency
__ Bloody urine
__ Genital Lesions
__ Other Genital or Urinary Symptoms

Skin Symptoms
__ Itching
__ Lesion/sores
__ Rashes
__ Other Skin Symptoms

Endocrine Symptoms
__ Excess Sweating
__ Excessive Thirst
__ Libido has changed

Musculoskeletal System
__ Joint Pain, localized
__ Joint Stiffness, localized
__ Muscle aches
__ Other Musculoskeletal Symptoms

Neurological Symptoms
__ Dizziness
__ Vertigo
__ Fainting
__ Difficulty Moving/walking
__ Changes in sensation
__ Numbness/tingling

Psychological Symptoms
__ Sleep Disturbances
__ Anxiety
__ Depression
__ Other Psychological Symptoms

__ Other (Please specify below):

_____

_____

_____

Reviewed by: _____ **on** _____
Provider Date