









**Sparks Clinic**

Patient Health History

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**What do you prefer to be called? (nickname):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**What brings you in today?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:**

|  |  |  |
| --- | --- | --- |
| **Medication Name**  | **Dosage (how much)** | **Directions (times per day)** |
|  |  |  |
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 **Allergies:**

|  |  |
| --- | --- |
| **Medication/Food/Etc.** | **Reactions** |
|  |  |
|  |  |
|  |  |

**Are you current on vaccinations?**  No  Yes  **Date of last Tetanus booster:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Do you currently see any other physicians/specialists****?**  No  Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Past Medical History:**

*Please check all that apply.*

**** No Past Medical History (*if checked, skip to third page*)

**Cardiovascular**

Arrhythmia (irregular heartbeat)  Blood Clot  Congestive Heart Failure  Hypertension

 Coronary Artery Disease (CHD)  Deep Venous Thrombosis (DVT)  Hyperlipidemia  Stroke

 Heart Attack  Peripheral Vascular Disease (PVD)  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Pulmonary**

 Asthma  Bronchiectasis  Chronic Bronchitis  COPD

 Croup  Pneumonia  Pulmonary Embolism  RSV

 Sleep Apnea  Tuberculosis (TB)  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Gastrointestinal**

 Cholelithiasis (gallstones)  Cirrhosis (liver disease)  Colon Polyps  Crohn’s Disease

 GERD  Hepatitis  Irritable Bowel Syndrome  Pancreatitis

 Peptic Ulcer Disease  Ulcerative Colitis  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Renal/Genitourinary**

 Acute Renal Failure  Chronic Renal Failure  Endometriosis  Kidney Stones

 Polycystic Ovarian Syndrome  Urinary Incontinence  UTI (recurrent)
 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Musculoskeletal/Connective Tissue**

 Chronic Pain  Fibromyalgia  Fractures  Gout

 Osteoarthritis  Osteoporosis  Rheumatoid Arthritis  Sjogren’s Disease

 Systemic Lupus Erythematosus  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Endocrine**

 Diabetes, Type 1  Diabetes, Type 2  Hyperthyroidism  Hypothyroidism

 Osteoporosis  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Neurological/Genetic**

 Alzheimer’s disease  Attention Deficit Disorder (ADD)  ADHD  Autism

 Cerebral Palsy  Cerebrovascular Accident  Dementia  Down Syndrome

 Disc Disease w/Radiculopathy  Headaches, Migraine  Headaches, Tension  Meningitis

 Multiple Sclerosis  Parkinson’s Disease  Seizure Disorder

 Special Needs (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Hematologic**

 Hemolytic Anemia  Iron Deficiency Anemia  Myelofibrosis  Pernicious Anemia Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Allergy/Immunology/Dermatology**

 Allergies  Chicken Pox  Eczema  Immunodeficiency  Otitis Media, Frequent  Psoriasis  Sinusitis, Frequent

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Cancers**

 Bone Cancer  Brain Tumor  Breast Cancer  Cervical Cancer

 Colon Cancer  Endometrial Cancer  Hepatic Carcinoma  Leukemia

 Lung Cancer  Lymphoma  Melanoma  Ovarian Cancer

 Pancreatic Cancer  Renal Carcinoma  Skin Cancer  Thyroid Cancer

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Other/Miscellaneous**

 Cataract  Glaucoma  Medication noncompliance  Obesity

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Gynecological History (females)**

Gravida (# of pregnancies): \_\_\_\_\_\_\_ Parity (# of births): \_\_\_\_\_\_\_ Abortions: \_\_\_\_\_\_\_ Miscarriages: \_\_\_\_\_\_\_

Problems with Pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Problems with Cycles: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Birth Control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of Menarche: \_\_\_\_\_\_ Age at Menopause: \_\_\_\_\_\_

Pap Smears:  Never or Date of Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Normal  Abnormal Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammograms:  Never or Date of Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Normal  Abnormal Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 **Hospitalizations**

**** No Hospitalizations **** Yes
Reason/Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History
** No Surgical History **** Yes Medical Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery/Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cosmetic Procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organ Removal/Resection:

 Appendectomy  Cholecystectomy  Colon Resection  Hysterectomy
 Laryngectomy  Lung Resection  Parathyroidectomy  Sinusectomy

 Thyroidectomy  Tonsil/Adenoidectomy  Vasectomy

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatric/Adolescent Procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Mother** | **Father** | **Sister** | **Brother**  | **Daughter** | **Son** |   **Grandmother**maternal | paternal |  **Grandfather**maternal | paternal |
| **AIDS**  |  |  |  |  |  |  |  |  |  |  |
| **Alcoholism** |  |  |  |  |  |  |  |  |  |  |
| **Alzheimer’s** |  |  |  |  |  |  |  |  |  |  |
| **Asthma** |  |  |  |  |  |  |  |  |  |  |
| **Attention Deficit Disorder**  |  |  |  |  |  |  |  |  |  |  |
| **Benign Prostatic Hypertrophy** |  |  |  |  |  |  |  |  |  |  |
| **Breast Cancer** |  |  |  |  |  |  |  |  |  |  |
| **Cerebrovascular Accident**  |  |  |  |  |  |  |  |  |  |  |
| **Colon Cancer** |  |  |  |  |  |  |  |  |  |  |
| **COPD** |  |  |  |  |  |  |  |  |  |  |
| **Coronary Artery Disease** |  |  |  |  |  |  |  |  |  |  |
| **Diabetes, Type 1** |  |  |  |  |  |  |  |  |  |  |
| **Diabetes, Type 2** |  |  |  |  |  |  |  |  |  |  |
| **Heart Attack** |  |  |  |  |  |  |  |  |  |  |
| **Hepatitis** |  |  |  |  |  |  |  |  |  |  |
| **HIV** |  |  |  |  |  |  |  |  |  |  |
| **Hyperthyroidism** |  |  |  |  |  |  |  |  |  |  |
| **Hypothyroidism** |  |  |  |  |  |  |  |  |  |  |
| **Lung Cancer** |  |  |  |  |  |  |  |  |  |  |
| **Obesity** |  |  |  |  |  |  |  |  |  |  |
| **Ovarian Cancer** |  |  |  |  |  |  |  |  |  |  |
| **Prostate Cancer** |  |  |  |  |  |  |  |  |  |  |
| **Seizure Disorder** |  |  |  |  |  |  |  |  |  |  |
| **Other** |  |  |  |  |  |  |  |  |  |  |
| **Other**  |  |  |  |  |  |  |  |  |  |  |
| **Other** |  |  |  |  |  |  |  |  |  |  |

**Social History**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status:  Married  Single  Divorced  Widowed  Cohabitation  Separated
Who lives with you at home?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Number of Children: \_\_\_\_\_\_\_ Number of Step-Children: \_\_\_\_\_\_\_ Number of Foster Children: \_\_\_\_\_\_\_

Do you feel safe at home?:  No  Yes Do you feel safe in your current relationship?:  No  Yes

**Exercise:** None  Aerobics  Cycling  Dancing  Running  Jogging  Walking  Swimming

 Weight Lifting Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency:  Daily  1-3 times/week  4-6 times/week  Rarely  Never  Other/Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Minutes per Session: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco/Alcohol/Supplements**

**Tobacco**:
Type:  Never  Cigarettes  Cigars  SmokelessTobacco  E-cigarette  Gum  Patch
Quantity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Past Use:  No  Yes If yes, how many/much per day?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Quit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol:**

Frequency:  Never  Non-drinker Rare  Experimented With  Social  Regular Use  Binge

Amount: \_\_\_\_\_\_\_\_\_\_ per *day*, *week* or *month* (circle one) Type of alcohol consumed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Caffeine:**
Type:  None  Coffee  Tea  Soda  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Quantity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supplements:**
Type:  AppetiteSuppressants Creatine Ephedrine Fat Burners Ginseng Xenadrines
 Other/Herbal Remedies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specialized Diets:**
Type:  None  Atkins  Blood Type  Herbalife  Mayo Clinic  Nutrisystem  Pritikin

 South Beach  Vegan  Vegetarian  Weight Watchers  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Abuse History:**

**** No Substance Abuse History  Amphetamines  Barbiturates  Benzodiazepines  Cocaine  Ecstasy
 Hallucinogens  Heroin  Inhalants  LSD  Marijuana  PCP  Mushrooms  Narcotics  Sedatives
 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health History:**

*Please indicate if you have ever been diagnosed with any of the following.*

 No Mental Health History  Anxiety Disorder  Eating Disorder  Depression  Bipolar Disorder

 Obsessive-Compulsive Disorder  Schizophrenia  Psychosis  Sleep Disorder  Other/Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Communicable Disease History:**

**** No Communicable Disease History  AIDS  Chlamydia  HPV  Gonorrhea  Herpes  HIV  Syphilis  Hepatitis A, B, or C (*circle one*)  Lyme Disease  Measles  Meningitis  Mumps  Pertussis  Rubella
 Tetanus  Tuberculosis  Other/Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I certify that, to the best of my knowledge and belief, the statements and documentation noted on this health history form are true and correct.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**