UnityPoint Clinic Multi-Specialty
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PATIENT HISTORY FORM

Instructions: Fill in the blanks, circle or put an "x" in the boxes as requested. Please print.
Date completed:_____

PATIENT INFORMATION

Last Name_____ First Name_____ Middle Name_____

Date of Birth_____ Home Phone # (____) _____ Work Phone# (____) _____

Cell Phone# (____) _____ Email address_____

Do you have a Living Will or Advance Directive? ☐ Yes ☐ No If yes, please bring a copy of it with you to your appointment.

Race/Ethnicity: White ☐ Black ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Indian ☐
Hispanic ☐ Multi- Racial ☐ Unknown ☐ Other _____

Native language: _____

Do you smoke? Yes ☐ No ☐ Former smoker? Yes ☐ No ☐ Tobacco user? Yes ☐ No ☐

Do you see any other physicians regularly? ☐ No ☐ Yes
Name_____ Phone # (____) _____

Address_____

Do you want a summary of this visit sent to this person? ☐ Yes ☐ No

MEDICATIONS

List ALL prescription and non-prescription medications, vitamins and supplements. Also include oxygen, CPAP/BiPAP or nebulizer.

Name of Medication	Dose	How often taken	Reason for medication

ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions to any medications? ☐ No ☐Yes
If Yes, fill out the following:

Name of Medication	Describe the allergic reaction:

Have you ever had an allergic reaction to Iodine or X-ray contrast dye? ☐ No ☐ Yes
Have you ever had an allergic reaction to rubber or latex? ☐ No ☐ Yes

FOOD ALLERGIES

Name of food	Describe the allergic reaction:

IMMUNIZATIONS – Have you received the following:

Immunization	Unknown	No	Yes	Approximate year given
Pneumococcal (pneumonia				
Hepatitis B				
Tetanus/Diphtheria with past 10 years				
Influenza (flu)				
Measles				
Mumps				
Rubella				
Polio				
Shingles/Zostavax				

PAST MEDICAL PROCEDURES/SURGERIES:

No past surgical history ☐

PERSONAL MEDICAL HISTORY – Have you had any medical problems with any of the following:			
Yes		**Yes**	
	EYES		**GENITOURINARY**
☐	Cataracts	☐	Abnormal pap smear
☐	Diabetic retinopathy	☐	Benign Prostatic Hypertrophy
☐	Glaucoma	☐	Cervical spondylosis
☐	Macular degeneration	☐	Erectile Disorder
☐	Retinal detachment	☐	Frequent urinary tract infections
☐	Other:	☐	Kidney disease
	EARS, NOSE AND THROAT	☐	Kidney stones
☐	Allergic rhinitis	☐	Last menstrual cycle?
☐	Fractured nose	☐	Menopause
☐	Hearing loss	☐	Ovarian Cyst
☐	Meniere's disease	☐	Prostatitis
☐	Nasal polyps	☐	Stress incontinence
☐	Recurrent sinus infections	☐	Testicular problems
☐	Rhinitis	☐	Urinary Incontinence
☐	Sinusitis	☐	Other
☐	Tracheostomy		
☐	Vocal Cord Dysfunction		
☐	Other:		
	RESPIRATORY		
☐	Asbestosis		**INTEGUMENTARY (SKIN)**
☐	Asthma	☐	Burns
☐	Bronchiectasis	☐	Dermatitis
☐	Bronchitis	☐	Eczema
☐	Chronic obstructive lung disease (COPD)	☐	Psoriasis
☐	Cough	☐	Skin Cancer Type:
☐	Dyspnea	☐	Other
☐	Emphysema		
☐	History of coughing up blood		
☐	Histoplasmosis		
☐	Interstitial Lung Disease	☐	**NEUROLOGICAL/PSYCHIATRIC**
☐	Lung Cancer	☐	Anxiety
☐	Obesity Hypoventilation Syndrome	☐	Depression
☐	Pleural Effusion	☐	Diabetic neuropathy
☐	Pleurisy	☐	Dizziness
☐	Pneumonia	☐	Drug use
☐	Pneumothorax	☐	Epilepsy
☐	Pulmonary embolism	☐	Fatigue
☐	Pulmonary Nodules	☐	Headaches
☐	Restrictive Lung Physiology	☐	Insomnia
☐	Respiratory Failure	☐	Migraine headaches
☐	RMLS	☐	Mental illness
☐	Sarcoidosis	☐	Peripheral neuropathy (unknown cause)
☐	Sleep Apnea	☐	Post-traumatic stress disorder
☐	Other	☐	**Stroke**
		☐	Tension headaches
		☐	Other:

	CARDIOVASCULAR		CANCER
☐	Aortic Aneurysm	☐	Bladder cancer
☐	Arrhythmia	☐	Breast cancer
☐	Cardiac Catheterization	☐	Cervical cancer
☐	Cardiomyopathy	☐	Colon cancer
☐	Congestive heart failure	☐	Kidney cancer
☐	Coronary Artery Disease (CAD)	☐	Leukemia
☐	Diastolic dysfunction	☐	Liver cancer
☐	Edema	☐	Lung cancer
☐	Hyperlipidemia	☐	Ovarian cancer
☐	Hypertension	☐	Throat cancer
☐	Hypotension (low blood pressure)	☐	Prostate cancer
☐	Myocardial infarction (Heart attack)	☐	Skin Type:
☐	Paroxysmal atrial fibrillation	☐	Uterine cancer
☐	Peripheral artery disease	☐	Other:
☐	Phlebitis?		
☐	Pulmonary hypertension		**CHILDHOOD DISEASES**
☐	Rheumatic fever?	☐	Chicken pox (Varicella)
☐	Thromboembolic disease (blood clot hx)	☐	Measles (rubeola)
☐	Valvular heart disease	☐	Mumps
☐	Other:	☐	Rubella (German measles)
		☐	Other:
	ENDOCRINE		**INFECTIOUS DISEASES**
☐	Adrenal disorder	☐	Chlamydia
☐	Diabetes ☐Type 1 ☐ Type 2 ☐ Gestational	☐	Genital warts (HPV)
☐	Impaired Fasting Glucose	☐	Gonorrhea
☐	Obesity	☐	Herpes (HSV)
☐	Polycystic ovarian disease	☐	HIV infection
☐	Thyroid disease Type:	☐	Shingles
☐	Vitamin D Deficiency	☐	Syphillis
☐	Other:	☐	Tuberculosis
		☐	Other:

Yes		Yes	
	GASTROINTESTINAL		**AUTOIMMUNE DISORDERS**
☐	Barrett's	☐	Allergy
☐	Cirrhosis	☐	Autoimmune disorder
☐	Colon polyps		
☐	Complete colonoscopy (date):		**PREGNANCY HISTORY/COMPLICATIONS**
☐	Crohn's (granulomatous) colitis	☐	Gestational diabetes
☐	Diverticular disease	☐	Preeclampsia
☐	Gastro esophageal reflux disease (GERD)		How many have you had:
☐	Helicobacter pylori		Pregnancies ____ Live births ____
☐	Hepatitis		Stillbirths ____ Miscarriages ____
☐	Hiatal Hernia	☐	Pregnancy Induced Hypertension
☐	IBS	☐	Premature birth
☐	Peptic ulcer	☐	Other:
☐	Ulcerative Colitis		
☐	Other:		

	MUSCULOSKELETAL		HEMATOLOGY
☐	Arthritis	☐	Anemia
☐	Carpal Tunnel Syndrome	☐	Blood Disorders
☐	Fracture(s)	☐	Blood Transfusion
☐	Gout	☐	Polycythemia
☐	Osteoporosis		
☐	Osteopenia		**RHEUMATOLOGY**
☐	Restless Leg Syndrome	☐	Fibromyalgia
☐	Spinal Stenosis	☐	Vasculitis
☐	Other:	☐	Polymyalgia Rheumatica
		☐	Scleroderma
			OTHER:
		☐	**Hospitalizations**
		☐	Injuries/Accidents
		☐	Physical abuse
		☐	Sexual abuse

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Work status: ☐ Working full time ☐ Working part time ☐ Unemployed ☐ Retired ☐ Disabled

Occupation: _____

Travel history (outside U.S.): _____

USE OF CORRECTIVE DEVICES

Currently wearing dentures? ☐ Yes ☐ No
Currently wearing contact lenses? ☐ Yes ☐ No
Currently wearing eyeglasses? ☐ Yes ☐ No
Currently wearing hearing aids? ☐ Yes ☐ No

Durable medical equipment use: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Brace ☐ Other: _____

HABITS

Recreational drug use: _____

Alcohol use (amount): _____

FAMILY HISTORY

Complete the following information about your BLOOD relatives:
F = Father, M = Mother, B = Brother, S = Sister, PGF = Paternal grandfather, PGM = Paternal grandmother, MGF = Maternal grandfather, MGM = Maternal grandmother, SON = Son, DAU = Daughter

Yes		Family member	Yes		Family member
	ALLERGY			**NEOPLASM (Continued)**	
☐	Drug allergies		☐	Other cancer within family	
☐	Non-drug allergies		☐	Ovarian cancer	
			☐	Prostate cancer	
	RESPIRATORY		☐	Skin cancer Type:	
☐	Asthma		☐	Throat cancer	
☐	COPD		☐	Uterine cancer	
☐	Emphysema				
☐	Sleep apnea				
	CARDIOVASCULAR			**MUSCULOSKELETAL**	
☐	Bleeding problems		☐	Arthritis	
☐	Clotting problems		☐	Osteoporosis	
☐	Coronary artery disease				
☐	Heart disease			**GENITOURINARY**	
☐	High cholesterol		☐	Kidney disease	
☐	High blood pressure		☐	Multiple births	
☐	Stroke				
				SOCIAL/PSYCHOLOGICAL	
	ENDOCRINE		☐	Alcoholism	
☐	Diabetes Type:		☐	Depression	
☐	Thyroid disease/goiter		☐	Drug abuse	
			☐	Mental illness (not retardation)	
	NEOPLASM				
☐	Bladder cancer			**GENETIC/OTHER**	
☐	Breast cancer		☐	Birth defects	
☐	Cervical cancer		☐	Chronic disabling diseases	
☐	Colon cancer		☐	Deafness before age 5	
☐	Laryngeal cancer		☐	Early deaths	
☐	Liver cancer		☐	Family history unobtainable	
☐	Lung cancer		☐	Genetic disease	

ADDITIONAL FAMILY HISTORY: