

PATIENT HEALTH HISTORY

DOB:		Name:				Male 🗖 Female				
Coccupation: Pharmacy: Coccupation: Primary Care Provider: Location: Referring Provider: Location: Left Right		DOB:	Age:	Height:	Weight:					
Primary Care Provider: Location: Referring Provider: Location: Referring Provider: Location: Referring Provider: Location: Referring Provider: Location: Location: Referring Provider: Location: Left Right Righ					DI					
Reason for today's visit:	CLINIC	_								
Reason for today's visit:		Primary Care	Provider:		Location:					
Set his the result of a:		Referring Pro	ovider:		Location:					
Is this the result of a:	Reason for today's visit:					☐ Left ☐ Right				
Date of onset:										
Briefly describe how the injury occurred: What makes it feel worse: What makes it feel better: What is it keeping you from being able to do? Describe your pain: achy sharp burning Any related symptoms? pain swelling bruising numbness Current pain level (1-10, 10 being the worst): Pain at its worst: Pain at rest: Pain with activity: Have you consulted with other health care providers (doctors, physical therapists, chiropractors, etc.) for this problem? Yes No If yes, please list below: Provider: Treatment: Approximate date:					•					
What makes it feel worse: What makes it feel better: What is it keeping you from being able to do? Describe your pain: achy sharp burning Any related symptoms? pain swelling bruising numbness Current pain level (1-10, 10 being the worst): Pain at its worst: Pain at rest: Pain with activity: Have you consulted with other health care providers (doctors, physical therapists, chiropractors, etc.) for this problem? Yes No If yes, please list below: Provider: Approximate date: Do you not feel safe at home? Yes Provider: Approximate date: Beautiful of the following, is your primary care physician/provider aware of your symptoms? Yes No (Please note that if your primary care physician/provider is not aware of any of these symptoms that you should notify him/her.) Addominal Dizziness Nausea Nausea Nausea Anxiety Excessive bruising Night sweats Rash Balance issues Excessive bruising Shortness of breath Chest pain Headaches Urinary changes Cough Heartburn/reflux Womiting Weight loss PAST MEDICAL HISTORY: Check all that Apply or I have none of these below. **Do you have, have you had, and/or do you take medications for: Rheumatoid arthritis Blood clots/DVT/PE Kidney disease Sice panea Blood clots/DVT/PE Kidney disease Sice Sice panea Blood clots/DVT/PE Kidney disease Sice Sice Cancer - type: MRSA infection Thyroid disease Cancer - type: Thyroid disease Cancer - type: Thyroid disease Cancer - type: Thyroid disease Cancer - typ	·	_								
What is it keeping you from being able to do? Describe your pain: achy sharp burning Any related symptoms? pain swelling bruising numbness Current pain level (1-10, 10 being the worst): Pain at its worst: Pain at rest: Pain with activity: Have you consulted with other health care providers (doctors, physical therapists, chiropractors, etc.) for this problem? Yes No If yes, please list below: Provider: Approximate date: Do you not feel safe at home? Yes REVIEW OF SYSTEMS: Check all that Apply If yes to any of the following, is your primary care physician/provider aware of your symptoms? Yes No (Please note that if your primary care physician/provider is not aware of any of these symptoms that you should notify him/her.) Anxiety Dizziness Nausea Night sweats Arm numbness/tingling Excessive thirist Rash Balance issues Fevers, chills Shortness of breath Chest pain Headaches Urinary changes Personant Per		ccurred.								
What is it keeping you from being able to do? Describe your pain: achy sharp burning Any related symptoms? pain swelling bruising numbness Current pain level (1-10, 10 being the worst): Pain at its worst: Pain at rest: Pain with activity: Have you consulted with other health care providers (doctors, physical therapists, chiropractors, etc.) for this problem? Yes No If yes, please list below: Treatment: Approximate date: Do you not feel safe at home? Yes REVIEW OF SYSTEMS: Check all that Apply If yes to any of the following, is your primary care physician/provider aware of your symptoms that you should notify him/her.) Abdominal pain Dizziness Nausea Nausea Anxiety Excessive bruising Night sweats Rash	What makes it feel worse:									
Describe your pain: achy sharp burning Any related symptoms? pain swelling bruising numbness Current pain level (1-10, 10 being the worst): Pain at its worst: Pain at rest: Pain with activity: Have you consulted with other health care providers (doctors, physical therapists, chiropractors, etc.) for this problem?	What makes it feel better:									
Any related symptoms?	What is it keeping you from being	What is it keeping you from being able to do?								
Current pain level (1-10, 10 being the worst):	Describe your pain: ☐ achy ☐									
Current pain level (1-10, 10 being the worst):										
Have you consulted with other health care providers (doctors, physical therapists, chiropractors, etc.) for this problem? Yes										
Yes No If yes, please list below: Provider:										
Provider: Treatment:										
Do you not feel safe at home?	•		.4.		A manazzimata data					
REVIEW OF SYSTEMS: Check all that Apply If yes to any of the following, is your primary care physician/provider aware of your symptoms?	Tiovidei.	Treatmen	IL		Approximate date.					
REVIEW OF SYSTEMS: Check all that Apply If yes to any of the following, is your primary care physician/provider aware of your symptoms?	Do you not feel safe at home?	J Yes								
PAST MEDICAL HISTORY: Check all that Apply or I have none of these below. PAST MEDICAL HISTORY: Check all that Apply or I have none of these below. Do you have, have you had, and/or do you take medications for: Anxiety Heart attack Psoriasis			7							
Abdominal pain										
Anxiety										
Arm numbness/tingling										
Balance issues	11111100)	<u> </u>			-					
Chest pain										
Depression			· · · · · · · · · · · · · · · · · · ·		Urinary changes					
PAST MEDICAL HISTORY: Check all that Apply or	Cough		Heartburn/reflux		Vomiting					
Do you have, have you had, and/or do you take medications for: Anxiety	Depression		Leg numbness/tingling		Weight loss					
Do you have, have you had, and/or do you take medications for: Anxiety										
Anxiety				ne of these below.						
Asthma		•			In · ·					
Diabetes □ Hypertension □ Seizures □ Blood clots/DVT/PE □ Kidney disease □ Sleep apnea □ Bowel disease □ Liver disease □ Stroke □ Cancer – type: □ MRSA infection □ Thyroid disease □										
Blood clots/DVT/PE			-							
Bowel disease										
Cancer – type:			•							
Form #4738 Created 01/27/16 Revised 8/23/2016										
Form #4738 Created 01/27/16. Revised 8/23/2016, 3/20/2017, 7/2017, 9/2018 Rutland Regional Medical Center Patient Label	Cancer – type.	<u> </u>	IVIKSA infection	J	i nyroid disease	<u> </u>				
3/20/2017, 7/2017, 9/2018 Rutland Regional Medical Center Patient Label	Form #4738 Created 01/27/16. Revise	ed 8/23/2016,	- n .1 in							
An Attiliate of Viitland Vegional Health Services		5	Kutland Regional	Medical Center	Pati	ent Label				
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Depression		Osteoporosis	П	Tuberculosis (TB)	
Gout		Pregnant (currently)		Ulcers	
	1			•	
AST SURGICAL HISTOR	PV		Uistony of anos	thosic problems? T Ves. T No.	
Procedure:				thesia problems? Yes No Surgeon:	
Troccuire.		Date:		Surgeon.	
IEDICATION LIST (inc	lude prescriptions b	erhals and over-	.the-counter medicatio	ns)	
Medication:				Times per day:	
Tributeurion:		Strength	n (dosage):	Times per un,	
LLERGIES	•	own Drug Allergi			
Medication You Are A	Hergic 10:		Reaction:		
<u>AMILY HISTORY</u> Do any	family members hav	ve or have had the	following (specify Mon	m, Dad, Brother, Sister)?	
Anesthesia problems			Diabetes		
Blood clots or pulmonary			Osteoarthritis or		
embolus	_		rheumatoid arthritis		
	_		Osteoporosis		
	_		MRSA infection		
			Heart attack		
OCIAL HISTORY					
Do you drink alcohol?	☐ Yes ☐ No	n If was how m	any drinks per day?		
Do you use tobacco?		-	How much?	For how many years?	
	LIES LIN	what type?	How much?	For now many years?	
Sports, hobbies, interests:	2 7 41 7	C /F 1 5	E' 1 5 N ' H	/A : . 1T: :	
What is your living situation	on?	Spouse/Family \Box	Friends Nursing Hom	ne/Assisted Living	
ate/Time:	Patien	t/Guardian Signat	ure:		
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evised 3/20/2017, 7/2017	ידר	KUUANG Keg10 An Affiliate of Rut	nal Medical Center land Regional Health Services	Patient Label	
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PATIENT HEALTH HISTORY cont'd