Victor Health Associates

Physical Health History Form

Patient Name: _____ **DOB**:_____

Date of Physical Appointment: _____

Select Primary Care Doctor:

☐ Dr. Barrett ☐ Dr. Hameed ☐ Dr. Piotrowski

☐ Dr. Meaker ☐ Dr. Penird

1. What are the top three items you would like to discuss at your physical appointment?

   a. _____

   b. _____

   c. _____

2. Please list a goal you would like to work on to improve your health this year:

   _____

3. Indicate any symptoms which you have had in the past year or now:

Concern	Past Year	Now	Concern	Past Year	Now
Blurred vision or vision loss			Abdominal pain		
Eye pain			Black/Tarry or bloody stools		
Frequent or severe headaches			Blood in vomit		
Ongoing sore throat / hoarse voice			Constipation		
Loss of balance			Diarrhea		
Loss of consciousness			Difficulty with swallowing		
Loss of hearing			Discoloration of skin		
Nasal congestion			Heartburn		
Seizures			Loss of appetite		
Swollen glands			Nausea		
Toothache			Unintentional weight loss		
Irregular or rapid heartbeat			Vomiting		
Chest pain			Weight gain		
Swelling in legs or feet			Bladder control problems		
Leg cramps with exercise			Pain or swelling of testicles		
Blue discoloration in Feet			Sores/Discharge from penis		
Cough, chronic			Pain with sex		
Cough, productive			Pain or lumps in breasts		
Shortness of breath			Prolonged/Heavy periods		
Snoring			Vaginal discharge		
Wheezing			Dizziness		
Cold/Heat intolerance			Tingling or numbness		
Difficulty sleeping			Weakness or paralysis		
Excessive thirst			Prolonged fever		
Excessive tiredness			Non-healing skin sore		
Frequent urination			Mole that changed		
Hot flashes			Skin lumps		
			Rash		

Medication/Drug History

1. Please list any supplements, herbal, or over the counter medications you may be taking:

_____

_____

2. Please list any new medications not prescribed by a provider of Victor Health Associates since your last visit (include dosage/prescriber):

_____

_____

3. Please list any specialists and/or recent surgeries/hospitalizations you have:

Specialists (name/specialty/last seen):	***Previous Surgeries / Hospitalization:***
1	1
2	2
3	3
4	4

4. Do you have any advanced directives? (If yes, please circle)
   Living Will Health Care Proxy Medical Orders for Life-Sustaining Treatment (MOLST)

Activities of Daily Living and Support

1. In the past 7 days, have you required assistance from others to perform everyday activities such as eating, getting dressed, bathing/showering, using the toilet or walking? ☐ Yes ☐ No

2. In the past 7 days, have you required assistance from others to take care of tasks such as laundry, housekeeping, banking, shopping, paying bills, food preparation, transportation, using the telephone or taking your medications? ☐ Yes ☐ No

3. If you utilize any assistive/support devices to help you get around please check the appropriate box: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Hearing Aids ☐ Other:_____

Nutrition and Physical Activity

1. Estimate the number of servings you consume of each of these foods daily:

Nutrients	*Number of Servings per Day*
Fruits / Vegetables	
Fiber	
High fat / Junk food	
Sweetened beverages (non-diet)	
Caffeinated beverages	

2. Tell me about your exercise routine:
   How many days a week do you exercise? _____ Minutes per day? _____

   What types of exercise do you do? _____

Social / Family History

Family History

1. # of Children_____

2. Please update the below section with any changes in your family history since your last physical.

	Father	Mother	Siblings	Children
Alive (Yes/No)				
Ages (or Age of Death)				
Any NEW family history				

Identify with M=Mother, F=Father, S=Sister, B=Brother, GM=Grandmother, GF=Grandfather

3. Lives with you in home (mark all that apply):
   Children Spouse Significant Other Extended Family Other: _____

Employment

1. Are you currently Employed? ▫ FT ▫ PT ▫ No What is your occupation? _____
2. Have you ever been exposed to radiation/radioactive materials at work? ▫ Yes ▫ No
3. Have you been exposed to any chemicals/irritants/hazardous materials at work? ▫ Yes ▫ No
   Type: _____

Safety/Sexual History

1. Do you feel unsafe with your partner/significant other? ▫ Yes ▫ No
2. Have you ever been sexually, physically, or emotionally abused? ▫ Yes ▫ No
3. Are you sexually active? ▫ Yes ▫ No
   a. If yes, what method of contraception do you use: ▫ None ▫ Birth control ▫ IUD ▫ Other:_____
   b. If yes, do you have more than one sexual partner? ▫ Yes ▫ No
   c. *Females only*: Date of your last menstrual period: Date: _____
4. Have you ever used recreational, street drugs, or prescription medications to get high within the past three years? ▫ Yes ▫ No
   a. If yes, select all that apply ▫ Cocaine ▫ Heroin ▫ LSD / Acid ▫ Marijuana ▫ Pain Meds ▫ Anabolic steroids
5. Has alcohol ever caused health, legal, driving, or relationship issues for you or a family member? ▫ Yes ▫ No
6. Do you consume alcoholic beverages (beer, wine, liquor)? ▫ Yes ▫ No
   a. If yes, how many drinks do you consume per week? _____/week

Signature of Patient: _____ Date:_____

Printed Name: _____