

# HC HIGHLAND CLINIC

FAX FORM TO 4451

DATE: \_\_\_\_\_

PATIENT HISTORY FORM

PCP / REFERRING MD  
\_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ Doctor \_\_\_\_\_

**Review of Systems: Do you have?**

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> Fever                 | <input type="checkbox"/> Ear Ache            | <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Heartburn                  | <input type="checkbox"/> Cold/Heat              |
| <input type="checkbox"/> Chills                | <input type="checkbox"/> Ear Drainage        | <input type="checkbox"/> Thyroid Nodule         | <input type="checkbox"/> Nausea                     | <input type="checkbox"/> Intolerant             |
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nasal Discharge     | <input type="checkbox"/> Swollen Glands         | <input type="checkbox"/> Vomiting                   | <input type="checkbox"/> Easy Bruising/Bleeding |
| <input type="checkbox"/> Weight change         | <input type="checkbox"/> Post Nasal Drip     | <input type="checkbox"/> Skin Growth/Sores      | <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Transfusion            |
| <input type="checkbox"/> Night Sweats          | <input type="checkbox"/> Stuffy Nose         | <input type="checkbox"/> Rash                   | <input type="checkbox"/> Headache                   | <input type="checkbox"/> Immunocompromised      |
| <input type="checkbox"/> Visual loss           | <input type="checkbox"/> Nose Bleeds         | <input type="checkbox"/> Itching                | <input type="checkbox"/> Migraines                  | <input type="checkbox"/> Anemia                 |
| <input type="checkbox"/> Itchy Eyes            | <input type="checkbox"/> Sneezing            | <input type="checkbox"/> Skin/Hair/Nail Changes | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Blood Clots            |
| <input type="checkbox"/> Tearing               | <input type="checkbox"/> Dental Problems     | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Numbness                   | <input type="checkbox"/> Snoring                |
| <input type="checkbox"/> Blurred/Double Vision | <input type="checkbox"/> Tonsillitis         | <input type="checkbox"/> Palpitations           | <input type="checkbox"/> Weakness                   | <input type="checkbox"/> Apnea                  |
| <input type="checkbox"/> Vertigo               | <input type="checkbox"/> Mouth Sores         | <input type="checkbox"/> Swelling Hands/Feet    | <input type="checkbox"/> Slurred Speech             |   |
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Hoarseness          | <input type="checkbox"/> Wheezing               | <input type="checkbox"/> Nervousness                |   |
| <input type="checkbox"/> Ringing Noise         | <input type="checkbox"/> Voice Changes       | <input type="checkbox"/> Coughing up Blood      | <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Insomnia               |
| <input type="checkbox"/> Hearing Loss          | <input type="checkbox"/> Problems Swallowing | <input type="checkbox"/> Chronic Cough          | <input type="checkbox"/> Depression                 | <input type="checkbox"/> daytime tiredness      |
|  | <input type="checkbox"/> Throat Pain         | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Excessive Thirst/Urination |   |

**Past Medical History: Have you had?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cancer – Specify _____ | <input type="checkbox"/> Depression/Anxiety    | <input type="checkbox"/> Thyroid Disease    |
| <input type="checkbox"/> Gerd / Reflux          | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> COPD / Emphysema       | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Allergy / Hayfever |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Asthma                |   |
| <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Mitral Valve Prolapse |   |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> High Cholesterol      |   |
| <input type="checkbox"/> High Blood Pressure    |  |   |

**Past Surgical History:**

- | <i>Have you had?</i>                   | <i>Year</i> |
|--|-------------|
| <input type="checkbox"/> Thyroid       | _____       |
| <input type="checkbox"/> Appendectomy  | _____       |
| <input type="checkbox"/> Hysterectomy  | _____       |
| <input type="checkbox"/> Gallbladder   | _____       |
| <input type="checkbox"/> Tonsillectomy | _____       |
| <input type="checkbox"/> Wisdom Teeth  | _____       |
| <input type="checkbox"/> Other _____   | _____       |

**Family History: Please indicate family member**

- |   |  |
|---|--|
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Rheumatologic Disease |
| <input type="checkbox"/> Heart Disease          |  |
| <input type="checkbox"/> Depression             |  |
| <input type="checkbox"/> Diabetes               |  |
| <input type="checkbox"/> Bleeding Problems      |  |
| <input type="checkbox"/> Cancer – Specify _____ |  |
| <input type="checkbox"/> Other _____            |  |

**Social History: Marital Status \_\_\_\_\_**

- Occupation: \_\_\_\_\_
- |   |     |                  |             |
|---|-----|------------------|-------------|
| <input type="checkbox"/> Tobacco Use                | Yes | No               | ___ Pks/Day |
| <input type="checkbox"/> Former Tobacco Use         | Yes | Year Quit: _____ |             |
| <input type="checkbox"/> 2 <sup>nd</sup> Hand Smoke | Yes | No               |             |
| <input type="checkbox"/> Alcohol Use                | Yes | No               |             |
| <input type="checkbox"/> Drug Use                   | Yes | No               |             |

**Allergies:** \_\_\_\_\_

**Medications:** Drug Name Dose/Strength/Directions Do you take blood thinners?  Yes  No

*All patients please complete medication list. Additional meds can be listed on the back of this sheet.*
