HIGHLAND CLINIC

FAX FORM TO 4451

DATE:_____ PATIENT HISTORY FORM PCP / REFERRING MD

_____

Name:_____DOB:_____Age:_____

Reason for Visit: _____

_____

_____

Allergies to Medications and Type of Reaction: _____

_____

Past Medical History: *Do you have?*

☐ None ☐ Heart Disease ☐ Lung Disease ☐ Diabetes ☐ Thyroid Disease ☐ Kidney Disease
☐ Cancer ☐ Liver Disease ☐ GERD/Reflux ☐ Asthma ☐ High Blood Pressure

Immunizations: *Are your immunizations up to date?* ☐ yes ☐ no

Pneumonia Shot _____year Seasonal Flu Shot _____year
H1N1 Flu Shot _____year Measles/Mumps/Rubella _____year
Prevanar _____year

Social History:

Smokes ☐ yes ☐ no ☐ former Type:_____ # per day_____ Years smoked_____
Second Hand smoke ☐ yes ☐no Alcohol Consumption ☐ yes ☐ no

Family History:

☐ None ☐ High Blood Pressure ☐ Heart Disease ☐ Depression ☐ Rheumatology Disease

Current Medications: *Drug Name Dose/Strength How you take it (for example, 1 a day, 2 a day, etc).*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Tell me about your home?

☐ Foundation☐ Pier Beam ☐ Foundation and Pier Beam
☐ Apartment ☐ Mobile home ☐ Townhome ☐Brick ☐Wood ☐ Brick & Wood
Age of Home_____
Has there been any water damage? ☐ yes ☐ no
Carpet ☐yes ☐no Age of carpet _____ Which rooms have carpet?_____
☐ Heating AC ☐ Gas Heat/Electric Air ☐Central heating Air ☐ Windows Unit

Bedroom Layout

How old is the mattress _____ Ceiling Fan ☐yes ☐ no
Pillow ☐ feather ☐ foam Blinds on Windows ☐ yes ☐ no
Pets ☐ yes ☐no Do any pets sleep in the bedroom ☐ yes ☐ no where ☐ bed ☐ floor ☐ cage

Hobbies: _____