EMERGENCY RESPONDERS HEALTH CENTER

Today's Date _____
Patient Name _____
Date of birth_____
Preferred Phone _____
Email _____

ESTABLISHED PATIENT – PERSONAL HISTORY FORM

Confidential

NAME: _____
(LAST NAME) (FIRST NAME) (PREFERRED NAME) (INITIAL)

AGE: _____ SEX: □ MALE □ FEMALE LAST PHYSICAL EXAM _____/_____
(DATE) (PRIMARY CARE PROVIDER)

CURRENT FIRE, POLICE OR EMS DEPARTMENT: _____ YEARS OF SERVICE: _____

SPECIAL OPERATIONS TEAM(S): (CIRCLE) ***HAZMAT*** ***DIVE*** ***TECH RESCUE*** ***CLAN LAB*** ***OTHER***_____

Address _____City _____ State _____ Zip _____

Phone (Home) _____ Phone (Cell) _____ Phone (Work) _____

Race (voluntary): □ American Indian □ Asian □ African American □ White □ Hispanic □ Other_____

Insurance Name_____ Group #_____ ID #_____

Pharmacy _____ Location _____

Updated Health History

Medications (prescription, OTC, vitamins) and Dosages:	**Allergies and Reactions:**
1.	
2.	
3.	
4.	
5.	**Injuries or Hospitalizations:**
6.	
7.	
8.	
Names of Health Care Providers or Specialists:	**Surgeries (type, date, surgeon, and hospital – if known):**
Any recent concerning exposures or injuries?	

Preventative Health Screening since we last saw you

Laboratory screening (ie: cholesterol, prostate, anemia): _____/_____
(DATE) (LOCATION)

Colonoscopy: _____/_____ Stool guiac: _____/_____
(DATE) (LOCATION) (DATE) (LOCATION)

Dental exam: _____/_____ Vision exam: _____/_____
(DATE) (LOCATION) (DATE) (LOCATION)

PAP Smear: _____/_____ Mammogram: _____/_____

Social History Update/Changes

Marital Status: _____
Work change: _____
Tobacco use: Yes or No (chew or smoke)
Alcohol use: Never, occas, weekly, daily
Caffeine use: Never, occas, weekly, daily
Drug use: Yes or No (type)

What are your goals for your health: _____

_____

In the next year? _____

_____

In the next 5 years? _____

Patient Self Evaluation and Review of Systems

Please review each item below and check any items that **currently** apply to you.

System and Problem	X	Describe	System and Problem	X	Describe
General			**Genital – Male**		
Fevers or chills			Reduced urinary flow		
Night sweats / Hot flashes			Frequent nighttime awakening to urinate		
Significant fatigue			Difficulty with erection		
Unusual bleeding or bruising			Lump/mass on testicle or in scrotum		
Swollen glands			Penile lesion, discharge or rash		
Unintended weight loss or gain			Difficulty with sexual relations		
Allergy and Immunologic			**Genital – Female**		
Hay fever			Recent change in menses		
Itchy, watery eyes or nose			Increasing pain with menses		
Frequent itchy, sensitive skin			Vaginal irritation, burning or discharge		
Persistent clear nasal drainage			Breast pain or tenderness		
Excessive or frequent infections			Breast lump or nipple discharge		
Eyes, Ears, Nose, Throat, Neck			Concerning rash		
Dramatic changes in vision			Difficulty with sexual relations		
Use of glasses or contacts			**Dermatology**		
Loss of hearing or use of hearing aids			Changing mole, bump, or growth		
Ear ache or drainage			Rash or skin problems		
Ringing in ears			**Musculoskeletal**		
Nose bleeds			Joint aches or pains		
Sinus pressure or pain			Joint swelling		
Sore throat			Significant morning stiffness		
Excessive snoring			Back pain		
Hoarseness more than 2 weeks			Numbness/tingling extremities		
Cardiovascular			**Lymphatic**		
Chest pain or pressure with exertion			Neck, armpit, or groin - swollen glands		
Unusual shortness of breath			**Neurologic**		
Palpitations			New or more severe headaches		
Irregular heart beats			Lightheadedness or fainting		
Increasing calf pain with walking			Unexplained loss of muscle strength		
Wounds with poor healing			Trouble with balance		
Swelling of extremities			Memory loss		
Unable to sleep lying flat			Difficulty with complex thought process		
Respiratory			**Endocrine**		
Worsening asthma or allergy symptoms			Markedly increased thirst or urination		
Chronic cough			Intolerance of heat or cold		
Blood tinged sputum			Excessive fatigue or loss of motivation		
Pain with deep breathing			Decrease in libido		
Difficulty breathing			**Psychiatric**		
Gastrointestinal			Feeling sad, blue, irritable, angry		
Abdominal pain			Feeling anxious		
Frequent heartburn			Decreased interest in hobbies		
Pain or difficulty swallowing			Suicidal thoughts		
Frequent nausea or vomiting			Preoccupations or compulsion		
Change in bowel habits			Difficulty with completion of tasks		
Increased constipation			**Others concerns or comments:**		
Frequent diarrhea					
Blood in stool or on toilet paper					
Black, tarry stools					
Urinary					
Burning with urination					
Increased urinary urgency or frequency					
Blood in urine					

Revised: 3/14/2016