



**EMERGENCY RESPONDERS
HEALTH CENTER**

Today's Date _____

Patient Name _____

Date of birth _____

Preferred Phone _____

Email _____

NEW 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** _____

Annual 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?	

CONDITIONS: Check those you have or have had in the past:

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hernia | <input type="checkbox"/> Stomach issues |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Herpes (HSV) | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Disorder | <input type="checkbox"/> High blood | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> pressure | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Thyroid issues |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dependency | <input type="checkbox"/> Liver disease | <input type="checkbox"/> West Nile Virus |
| <input type="checkbox"/> Crohn's | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Cancer(s) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraines | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriage | _____ |

Immunizations

When did you last have? (MM/YY)

Hepatitis A (2 shots) _____
Hepatitis B (3 shots) _____
Hepatitis B blood titer __ Pos or Neg__
Tetanus booster _____
MMR _____ Polio _____
Influenza/flu shot _____
Tuberculin skin test _____
Pneumovax _____
Shingles _____
Others _____

Other conditions not listed:

Patient Name _____

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 concerning 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					

Patient Name _____

Sexual Health Screening (Voluntary)

<p>Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you planning a pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Birth control method(s) currently using:</p> <table><tr><td><input type="checkbox"/> Hormone contraceptive</td><td><input type="checkbox"/> IUD</td></tr><tr><td><input type="checkbox"/> Nuvaring</td><td><input type="checkbox"/> Condoms</td></tr><tr><td><input type="checkbox"/> Withdrawal</td><td><input type="checkbox"/> Spermicide</td></tr><tr><td><input type="checkbox"/> Tubal ligation</td><td><input type="checkbox"/> Vasectomy</td></tr></table> <p>Other: _____</p> <p>Any concerns of infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Risk/concerns for sexually transmitted disease?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Would you like to speak with a provider about testing?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Hormone contraceptive	<input type="checkbox"/> IUD	<input type="checkbox"/> Nuvaring	<input type="checkbox"/> Condoms	<input type="checkbox"/> Withdrawal	<input type="checkbox"/> Spermicide	<input type="checkbox"/> Tubal ligation	<input type="checkbox"/> Vasectomy	<p style="text-align: center;">Females Only Section</p> <p>Have you ever been pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How many times? _____</p> <p>How many miscarriages? _____</p> <p>How many abortions? _____</p> <p>How many children do you have living? _____</p> <p>Do you have menstrual periods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, at what age did they stop? _____</p> <p>If yes, are your periods regular? _____</p> <p>History of abnormal Pap Smear?</p> <p>If yes, list date(s), provider name and treatment:</p> <p>_____</p>
<input type="checkbox"/> Hormone contraceptive	<input type="checkbox"/> IUD								
<input type="checkbox"/> Nuvaring	<input type="checkbox"/> Condoms								
<input type="checkbox"/> Withdrawal	<input type="checkbox"/> Spermicide								
<input type="checkbox"/> Tubal ligation	<input type="checkbox"/> Vasectomy								

Past Preventative Health Screening

Laboratory screening (cholesterol, glucose, etc.) _____ / _____
(DATE) (LOCATION)

Pap smear (female): _____ / _____ Mammogram (female): _____ / _____
(DATE) (PROVIDER/LOCATION) (DATE) (LOCATION)

DEXA (bone density): _____ / _____ Dermatology consult: _____ / _____
(DATE) (LOCATION) (DATE) (PROVIDER)

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

Colonoscopy: _____ / _____ EGD (upper endoscopy) _____ / _____
(DATE) (PROVIDER/LOCATION) (DATE) (PROVIDER/LOCATION)

What are your goals for your health: _____

In the next year? _____

In the next 5 years? _____

(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

(AUTHORITY OF RELATIONSHIP TO PATIENT)

(DATE)

Initial Review by Provider: _____ / _____
(DATE) (INITIAL)

Subsequent Reviews:

PATIENT	PROVIDER
_____ / _____	_____ / _____
_____ / _____	_____ / _____
_____ / _____	_____ / _____