# NEW PATIENT HEALTH HISTORY FORM

### Thank you for taking the time to complete this New Patient Health History Form. This form will become part of your medical record. Please fill in the circle next to your answer or clearly print your answer when asked. You may use a pen or pencil to complete this form.

**Today’s date: / /**

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Month Day Year

### Patient’s

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**Name: Date of birth: / /**

First Last Month Day Year

**Person completing this form:**  Patient

* Other: (indicate relationship to patient)

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| **Why have you come to the hospital today?** | **Who referred you here?**  **Who is your family doctor?**    Phone  **List any other doctors that you see:**    Phone    Phone |
| * Initial Consultation |
| * Second Opinion |
| * Transferring Care |
| * Other: |
| **What is your medical reason for coming to the** |
| **hospital?** |

# Personal History

Please fill in the circle for all **previous** illnesses or conditions below:

* Anxiety/Depression
* Arthritis
* Bleeding Disorder
* Bowel/Intestinal Problems
* Diabetes (high blood sugar)
* Glaucoma/Eye Problems
* Hearing Problems
* Heart Attack/Disease
* High Blood Pressure
* History of Blood Clots
* HIV/AIDS
* Kidney Problems
* Liver Disease
* Lung Problems
* Mental Health Problems
* Seizures
* Skin Problems
* Stomach Problems
* Stroke
* Thyroid Disease

### Other Health Problems:

**Do you have a pacemaker or internal defibrillator?**  Yes  No

Patient, please do not write in this space. (For Clinical Team Notes)

**Have you had any past surgeries?**  Yes  No

If **YES**, please list the surgery you had and the date:

Month Day

Year

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# Medication



**Have you ever had any prior cancers (before your current illness of cancer)?**

Yes

No

If **YES**, please list prior cancer, the date you were diagnosed, and the date of treatment completion:

Type of Cancer

Date of Diagnosis:

Date of Treatment Completion:

Month Day Year Month Day Year

/ / / /

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**Have you had prior chemotherapy?**

**Have you had prior radiation treatment?**

Yes

Yes

No

No

Please list any medications and supplements that you take on a daily or frequent basis. Include prescriptions and over-the-counter medications, vitamins, minerals, herbs, and any other supplements.

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| **Medication** | **Dose** | **How often** | **Route**  (oral, topical, etc.) | **What is it for?** |
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### Are you allergic to anything?

* No  Yes, list all allergies and describe your reactions below:

### Do you have any family history of chronic illnesses (for example, diabetes, heart disease or cancer)?

























**Family History**

Please complete the family history form for yourself and “blood” relatives. Mark the second column for half siblings. Do not include any adopted children or stepbrothers/stepsisters. If you are adopted, and you do not know your natural parents, just complete information about your children. Use a “**?**” whenever you are not sure of an answer. If necessary, it is acceptable to estimate a date or an age.

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| Relationship: | Half- Sibling: | Initials:  First, Middle, Last | Date of Birth:  Month / Year | Has this person ever had colonic polyps? | | | Has this If Yes, please list type person ever of cancer and age at had cancer? diagnosis: | | | Is this person If not, please list  still living? cause of death and age at death: | |
| Yes | No | Don’t Know | Yes | No | Don’t  Know Type: Age: | Yes | No Cause: Age: |
| You |  |  |  |  |  |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |  |  |  |  |  |
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| Brother Sister |  |  |  |  |  |  |  |  |  |  |  |
| Spouse/Parent  of your children: |  |  |  |  |  |  |  |  |  |  |  |
| Son Daughter |  |  |  |  |  |  |  |  |  |  |  |
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| Additional Spaces, please note relationships as needed: | | | | | | | | | | | |
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### Would you like a referral to the Center for Human Genetics at University Hospitals

**Cleveland Medical Center, which offers programs designed to help people with a**  Yes  No

**family history of cancer?**

**Personal Information**

**Gender:**

* Male
* Female

### What is your race?

*(Select all that apply)*

* American Indian or Alaskan Native
* Asian
* Black or African American
* Native Hawaiian or Other Pacific Islander
* White

### Are you Hispanic or Latino?

* Yes
* No

### Relationship Status:

* Single  Divorced
* Married  Widowed
* Separated  Partnered

### Spiritual practice/religious tradition:

**Employment Status: Occupation** (if applicable):

* Currently Working
* Retired
* On medical leave
* On disability
* Unemployed

### Did you serve in the military?

* Yes
* No

**Who do you consider to be your family?**

**Who is your main support person?**

**What is their relationship to you?**

**What is their phone number?**

**Whom can we share information**

**with?**

**Who takes care of you when you**

**are ill?**

**Living Accommodations:**

* House
* Apartment
* Extended Care Facility
* Other:

**How many children live in**

**your household?**

**If you have children living in your**

**household, what are their ages?**

**Living Arrangement:**

* Alone
* With family/friends

**Are there times when you**

**feel unsafe around people you know or live with?**

* No
* Yes



**Highest level of education**

**completed:**

Grade: High School

2 Year Degree

4 Year Degree Graduate Degree

**How do you learn?**

Reading Listening Practicing

Memorizing

Demonstration Other

**Do you need an**

**interpreter?**

No

Yes

**Do you have problems with:**

Hearing Speech Sight

**What is your primary**

**language?**

**Head & Neck**

* None
* Nose bleeds
* Hoarseness
* Sores in mouth or throat
* Sore throat

**Last dentist visit:**

**/**

**/**

**Breast**

* None
* Changes
* Lumps
* Nipple discharge

**Date of last mammogram:**

**/ /**

**Male Only**

* None
* Problems passing urine
* Enlarged prostate

**Date of last prostate exam:**

**/ /**

**Please list any other problems you are currently having:**

**Endocrine**

* None
* Cold intolerance
* Hot flashes

**Musculoskeletal**

* None
* Joint swelling
* Joint/back pain
* Stiffness
* Trauma
* Falls

**Heart**

* None
* Leg pain/swelling
* Chest pain
* Fast heart beat

**Neurological**

* None
* Memory changes
* Numbness/tingling
* Dizziness/fainting
* Weakness
* Blurred vision
* Headache
* Hearing difficulty
* Ringing in ears
* Seizures
* Speech changes
* Unbalanced walking

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| **Female Only**   * Unusual bleeding/discharge **Age at 1st menstrual period:**   **Date of last menstural period Age at 1st pregnancy:**  **/ / Number of pregnancies: Date of last pap smear Number of live births:**  **/ /** | |
| **Have you ever taken birth control?**   * Yes  No   If **YES,** how many years? | **Have you ever taken hormone replacement?**   * Yes  No   If **YES,** how many years? |
| **Are you pregnant now?**  Yes  No | |

# Current Health

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| e following problems that you have |  | |
| **Skin**   * None * Open sore * Change in moles * Abnormal color * Rashes | | **Urinary**   * None * Burning * Frequency * Dribbling * Unable to control bladder * Urgency |
|  | |

Please fill in the circle of all of th had in the past 3 weeks.

**General**

* None
* Fever/Chills
* Sweats
* Change in sleep habits
* Fatigue

**Lungs**

* None
* Wheezing
* Cough
* Short of breath
* Bloody phlegm/sputum

**Hematology**

* None
* Abnormal bleeding
* Prior transfusion
* Easy bruising
* Swelling in groin/armpit/neck

**Gastrointestinal and Nutrition**

* None
* Yellow skin or eyes
* Cramping or stomach pain
* Nausea/vomiting
* Problems swallowing
* Indigestion/heartburn
* Reflux
* Blood in stools
* Black stools
* Constipation
* Diarrhea

## Pain

### Are you currently having pain?

* + No
  + Yes (If yes, where?) **Fill in the circle next to the number that best describes your pain.**

 0  1  2  3  4  5  6  7  8  9  10

### No pain Worst possible pain

**Activity**

**Over the past month, I would rate my activity as:**

Normal, no limitations

Not my normal self, but able to be up doing fairly normal activities Not feeling up to most things, in bed or chair less than half of the day

Able to do little activity, spend more than half the day in bed or a chair Rarely out of bed or chair

### How would you rate your fatigue on a sale of 0-10 over the past 7 days?

0 1 2 3 4 5 6 7 8 9 10

### No Fatigue Worst fatigue you could imagine

**Home Health Care Used:**

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| **Do you need help with:**  Bathing/dressing Walking  Stairs  Preparing Meals Other: | **Yes** | **No** |
|  | | |

None

University Home Care VNA

Other:

### Community Agencies Used:

None

Support Group Meals on Wheels Other:

**Coping** It is normal to feel some distress when you are ill. Please fill in the circle next to the number that best describes your level of distress on average, **over the past week:**

 0  1  2  3  4  5  6  7  8  9  10

### No Distress Most severe distress

**Check the factors that you feel contribute to your distress:**

**Practical:**

* Housing
* Insurance
* Work/School
* Transportation
* Childcare
* Financial Concerns

### Physical:

* Pain
* Nausea
* Fatigue
* Sleep problems
* Getting around

### Emotional:

* + Worry
  + Sadness
  + Depression
  + Nervousness
  + Hopelessness

### Communication:

* + Communication with partner
  + Communication with children
  + Communication with doctor

### Spiritual/Religious: Concerns

* + - Relating to God
    - Loss of faith

### Would you like more information about a support group?  Yes  No

**Would you like more information about individual supportive counseling?**  Yes  No

**Diet**

**What is your current height and weight?**

**What did you weigh 1 month ago, 6 months ago and 1 year ago?**

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1 month 6 months 1 year

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Feet Inches Pounds

### How would you describe your diet?

Regular Low Cholesterol Diabetic Vegetarian

Low Salt Other: Low Fat

### Compared to normal, how would you rate your food intake during the past month?

Unchanged More than usual Less than usual

### My appetite is:

**What are you currently eating?**

Regular foods Soft foods

Liquid supplements Only liquids

Very Poor Poor Average Good Very Good



### Would you like to meet with our registered dietitian? Yes No

**Lifestyle**



**Exercise**

Moderate intensity exercise includes physical activities that get you breathing harder and your heart beating faster. Examples of exercise include setting aside time for things like: jogging, dancing, bike riding, aerobic classes, swimming, working out to an exercise video. Exercise does not include what you do at work. Use this definition to answer the questions below.

### During the last 6 days, on how many days did you do moderate intensity

**exercise for at least 10 minutes at a time without stopping? 0-7 days/week On those days, how much time did you spend on average doing the activities? minutes**

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**Walking fast (3-4 mph) is also exercise. During the last 7 days, on how many**

**days did you walk fast for at least 10 minutes at a time without stopping? 0-7 days/week On those days, how much time did you spend on average walking fast? minutes**

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**Compared to how physically active you have been over the last 3 months, how would you describe the last 7 days?**

More active About the same Less Active

**Have you ever used tobacco products?**

If **YES**, what type/s?

* Yes
* No
* Other tobacco (Snuff,

Hookah, Bidis, Kretecks etc.)

What product:

How often:

# of years

If **YES**, have you quit?  Yes - when?

* No

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| * Cigarettes |  |  | # packs/day |  |  | # of years |
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| * Cigars |  |  | # per day |  |  | # of years |
|  |  |  |  |  |  |  |
| * Little Cigars |  |  | # per day |  |  | # of years |
|  |  |  |  |  |  |  |
| * Chewing tobacco |  |  | # per day |  |  | # of years |



**Do you drink alcohol? (include beer & wine)**

Yes

No

If **YES**, how many **days** did you drink in the past week?

# days/week

If **YES**, how many **drinks** did you have in the past week?

# of drinks

**Did you previously drink alcohol, but have since quit?**

Yes

No

**Do you use recreational drugs?**  Yes  No

If **YES**, what drugs do you use and how often do you use them?

# days/week

# days/week

**Did you previously use recreational drugs, but have since quit?**  Yes  No

# Health Care Documents

|  |  |
| --- | --- |
| **Yes** | **No** |
| Do you have an Advance Directive? (Durable Power of Attorney for Health Care) |  |
| Do you want help completing an Advance Directive? |  |
| Do you have a living will? |  |
| Do you want help completing a living will? |  |
| Do you have a legal guardian? |  |

### What is your main concern regarding your illness and treatment?

**What else would you like us to know about you?**

**What questions may we answer for you?**

Thank you for completing this form. Please bring it with you to your doctor’s appointment.

Patient Signature

Healthcare Team Member Signature, Title Date Patient, please do not write in this space. (For Clinical Team Notes)