AdventHealth Centra Care

ANNUAL PERSONAL HEALTH HISTORY

Name: ______________________ **DOB:** ____________ **Date:** ______________

Current Medications and Dosage (include over-the-counter medications like Tylenol and Motrin) ☐ No Current Medications	**Medication**	**Dosage/Frequency**	**Medication**	**Dosage/Frequency**
Vitamins/Herbal Supplements?				
Allergies to Medication and What happens when you take this medication? ☐ No Known Allergies	**Medication**	**What Happens?**	**Medication**	**What Happens?**

Date of last Tetanus shot ____________ ☐ Less than 5 years ☐ Less than 10 years ☐ Unknown ☐ Current to Date (for children)

Past Medical History: Do you have any current or past medical problems? ☐ **Yes** ☐ **No**
If yes, check all boxes below that apply.

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign Prostatic Hypertrophy (Enlarged Prostate)
- ☐ Blood Clots
- ☐ Cancer __________
- ☐ Cardiac Arrythmia
- ☐ COPD (Emphysema)
- ☐ Coronary artery disease
- ☐ Crohn's disease (Other: Use 34000006)
- ☐ Depression
- ☐ Diabetes
- ☐ Elevated Lipids (High Cholesterol/Triglycerides)
- ☐ Gallbladder disease
- ☐ GERD(Acid Reflux)
- ☐ Headache / Migraine
- ☐ Heart attack (Use Myocardial Infarction)
- ☐ Heart Disease
- ☐ Heart Valve Disorder
- ☐ Hepatitis / Liver Disease
- ☐ Hepatitis C (Other: Use 50711007)
- ☐ Hypertension (High BP)
- ☐ Irritable bowel disease
- ☐ Osteoporosis
- ☐ Renal / Kidney disease
- ☐ Stomach ulcer disease (Other: Use 397825006)
- ☐ Seizure disorder
- ☐ Stroke (CVA)
- ☐ TB/Positive PPD (Other: Use 268376005)
- ☐ Thyroid disease
- ☐ Other ____________
- ☐ Other ____________

Past Surgical History: Have you ever had any surgeries? ☐ **Yes** ☐ **No If yes, check all boxes below that apply.**

- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ Back surgery
- ☐ Blood Transfusion
- ☐ CABG (Heart Bypass)
- ☐ Cardiac Pacemaker
- ☐ Carpal tunnel release
- ☐ Cataract extraction
- ☐ Cholecystectomy (Gallbladder removal)
- ☐ Colectomy/ Colon resection
- ☐ Gastric bypass
- ☐ Hernia repair
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ LASIK
- ☐ ORIF Surgical fracture repair
- ☐ Small bowel resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Other ______________

Males Only

- ☐ Prostate biopsy
- ☐ TURP (Prostate Resection)
- ☐ Vasectomy

Females Only: Medical and Surgical History

Date of Last Period: _____/_____/_____

☐ No period yet

☐ No longer having periods

Are you pregnant? ☐ Yes ☐ No
Trying to get pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

- ☐ Bilat. tubal ligation
- ☐ Breast augmentation
- ☐ Breast reduction
- ☐ Cesarean section (Other: Use 200144004)
- ☐ D and C
- ☐ Hysterectomy-Partial
- ☐ Hysterectomy-Total
- ☐ Hysterectomy-Vaginal
- ☐ Mastectomy
- ☐ Uterine fibroid removal (Other: Use 95315005)

Your Family History: Has anyone in your immediate family (Mom/Dad/Brothers/Sisters) suffered from the following; check all boxes that apply.

- ☐ Heart Attack (Coronary Artery Disease)
- ☐ Cancer Type:______________
- ☐ Stroke (CVA)
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension
- ☐ **No Relevant Family History**

Social Habits: Tobacco Use **If Yes,** ☐ **Everyday** ☐ **Heavy Smoker** ☐ **Some days** ☐ **Light Smoker**
If No, ☐ **Never a Smoker** ☐ **Former Smoker**
Alcohol Use ☐ **Yes** ☐ **No**

Primary Care Physician : ____

______________________________ ________________
Patient Signature **Date**

AHCC-400
Updated 3-2-2019