OhioHealth
BELIEVE IN *WE*

Personal Health Information

Name _____

Date _____ Date of Birth _____ Age _____

List all medications you take including any supplements or over the counter drugs:

Name of Drug	Dose (if known)	How Often

Please list any drug or food **allergies** _____

Your Medical History – Please mark if you have or have ever had any of the following diseases

- ☐ Cancer
  Type: _____
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Spastic Colon
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Kidney Stones
- ☐ Lung Disease/Emphysema
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcer
- ☐ Mitral Valve Prolaspe
- ☐ Glaucoma

Any **Hospitalizations**? Please note date and reason: _____

_____

_____

_____

Your Surgical History – Please mark if you have had any of the following surgeries

- ☐ Angioplasty
- ☐ Back Surgery
- ☐ Bladder
- ☐ Gall Bladder
- ☐ Heart By-Pass
- ☐ Heart Valve
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Kidney
- ☐ Kidney Stone
- ☐ Ovary
- ☐ Pacemaker
- ☐ Prostate
- ☐ Stomach Ulcer
- ☐ Tonsils

Other Surgery – Please specify _____

_____

_____

_____

Your Family History – Please mark if your Mother, Father, Brother, or Sister have ever had any of the following:

	Mother	Father	Sister	Brother
Bladder Cancer	Yes No	Yes No	Yes No	Yes No
Diabetes	Yes No	Yes No	Yes No	Yes No
Heart Disease	Yes No	Yes No	Yes No	Yes No
High Blood Pressure	Yes No	Yes No	Yes No	Yes No
Kidney Cancer	Yes No	Yes No	Yes No	Yes No
Kidney Disease/Failure	Yes No	Yes No	Yes No	Yes No
Prostate Cancer	Yes No	Yes No	Yes No	Yes No
Family History Unknown	Yes No	Yes No	Yes No	Yes No

Your Social History

Married? Y N W Occupation _____

Smoke? Y N _____ Packs per day for _____ years.

Caffeine Y N Type_____ Amount _____per Day

Drink Alcohol? Y N ___Occasional or ___On a regular basis ____Drinks per Day

Do you have the following symptoms or diseases?

General:				
Fatigue	Yes___ No___	Weight Loss	Yes___	No___
Fever	Yes___ No___	Weight Gain	Yes___	No___
Eyes:				
Blurred Vision	Yes___ No___	Glasses	Yes___	No___
Double Vision	Yes___ No___	Cataracts	Yes___	No___
ENT:				
Hearing Loss	Yes___ No___	Nose Bleeds	Yes___	No___
Ringing in the Ears	Yes___ No___	Trouble Swallowing	Yes___	No___
Cardiovascular:				
Chest Pain at Rest	Yes___ No___	Edema	Yes___	No___
Chest Pain with Exertion	Yes___ No___	Irregular Heartbeat	Yes___	No___
Palpitations	Yes___ No___			
Respiratory:				
Chronic Cough	Yes___ No___	Asthma	Yes___	No___
Shortness of Breath at Rest	Yes___ No___	Trouble Breathing -		
Shortness of Breath w/ Exertion	Yes___ No___	When Lying Down	Yes___	No___
Gastrointestinal:				
Nausea or Vomiting	Yes___ No___	Diarrhea	Yes___	No___
Heartburn	Yes___ No___	Blood in Stool	Yes___	No___

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Urinary:					
Difficulty Urinating	Yes___	No___	Urinary Incontinence	Yes___	No___
Painful Urination	Yes___	No___	Blood in Urine	Yes___	No___
Increased Frequency	Yes___	No___			
Genital/Reproductive:					
Sexual Problems	Yes___	No___	Currently Pregnant (Female)	Yes___	No___
Decreased Sexual Drive	Yes___	No___	Abnormal Menstrual Periods	Yes___	No___
Musculoskeletal:					
Leg Cramps	Yes___	No___	Leg Cramps with Walking	Yes___	No___
Skin:					
Rash	Yes___	No___	Concerning Skin Lesions	Yes___	No___
Neurologic:					
Headaches	Yes___	No___	Tremors	Yes___	No___
Fainting	Yes___	No___	Memory Loss	Yes___	No___
Mental Status:					
Anxiety	Yes___	No___	Bi Polar Disorder	Yes___	No___
Depression	Yes___	No___	Schizophrenia	Yes___	No___
Endocrine:					
Weight Gain	Yes___	No___	Post Menopausal (Female)	Yes___	No___
Weight Loss	Yes___	No___	Hot Flashes	Yes___	No___
Thyroid Problems	Yes___	No___			
Hematologic:					
Abnormal Bruising	Yes___	No___	Immune Deficiency	Yes___	No___
Abnormal Bleeding	Yes___	No___	Sickle Cell Disease or Trait	Yes___	No___
Anemia	Yes___	No___	Lupus	Yes___	No___
Trouble with Blood Clotting	Yes___	No___	Hepatitis C	Yes___	No___
Previous Transfusions	Yes___	No___	HIV	Yes___	No___