Andrea Axtell, M.D., PLLC • Ann Cordum, M.D., PLLC
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(208) 994-8656 • fax (208) 429-1332
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# HEALTH HISTORY

Date:

Name:
Date of Birth:
Age:

Other physicians involved in your care:

_____ _____
_____ _____

Concerns you would like to address:

_____
_____
_____

Medication Allergies:

_____ _____

Medications and dosages:

_____ _____
_____ _____
_____ _____
_____ _____

Over the counter medications, supplements and herbal remedies that you take:

_____ _____
_____ _____
_____ _____

Please list all medical problems and diagnoses- including infancy, childhood, pregnancies and adulthood (use additional page if needed). Please include dates and/or age:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list past surgeries and procedures - Include physician, date or age at time of surgery and physician:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever been a smoker?
age started: _____ number of years: _____
packs per day: _____ date quit: _____

Occupation: _____
With whom do you live? _____
How many alcoholic beverages per day/week/month? _____
Other drug use (marijuana, cocaine, heroin, crack, meth, etc. ) _____
Are you concerned about your alcohol or drug intake? _____
You have the right to be safe and respected. Do you have concerns for your safety?_____
Foreign countries visited/dates:_____
Pets in home? Type? _____

**FAMILY HISTORY**

| | Father | Mother | Brother/Sister | Brother/Sister | Brother/Sister | Brother/Sister |
|---|---|---|---|---|---|---|
| age | | | | | | |
| cancer/age at diagnosis | | | | | | |
| heart disease | | | | | | |
| diabetes | | | | | | |
| autoimmune disease | | | | | | |
| high cholesterol | | | | | | |
| Other | | | | | | |
| Age at death | | | | | | |

Health Maintenance: Please provide date and results of last exam.



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1. Immunizations and dates, if available: _____
2. Mammogram:_____
3. Pap/pelvic:_____History of abnormality?_____
4. Colonoscopy: _____
5. Cholesterol: _____
6. Bone density: _____
7. Dental: _____
   - How many fillings? _____
   - How many root canals? _____
   - Do you wear dentures?_____
8. Eye: _____
   - Do you wear eyeglasses or contacts? _____
9. Exercise:
   - Type _____Frequency _____
   - Minutes/hours per week?_____
10. Method of contraception: _____

*WOMEN ONLY*:

11. Date of last menstrual period: _____
12. Age at onset of menses: _____
13. Number of pregnancies: _____
14. Number of therapeutic or spontaneous abortions:_____

**Within the *LAST 2 MONTHS* have you experienced any of the following? Please circle.**

| | | |
|---|---|---|
| fatigue | exposure to chemicals/toxins | sense of lump on swallowing |
| fever or chills | exposure to second hand smoke | hemorrhoids |
| night sweats | nausea/vomiting | blood in stool |
| heat or cold intolerance | diarrhea | mucous in stool |
| weight loss/gain_____ | constipation | black or tarry stools |



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# bowel movements/day: _____
heartburn
history of hepatitis/yellow skin
painful urination
frequent urination
frequent nighttime urination
urinary tract infections
urinary urgency
difficulty emptying bladder
slow urinary stream
leakage of urine
blood in urine
incontinence
chest pain
chest tightness
leg swelling
calf pain on walking
leg cramps
cough
coughing up blood
asthma/wheezing
snoring
difficulty breathing when lying flat
shortness of breath
seizures
numbness
weakness
tremor
unstable walk
frequent falls
memory loss
headache

change in vision
blurred vision
glaucoma
cataracts
head injury
decreased hearing
ear infections/drainage
congestion
tooth pain
history of strep throat
voice change
hoarseness
difficulty swallowing
pain on swallowing
history of thrush
frequent infections
sexually transmitted infection
muscle aches
joint pain
joint swelling
stiffness
bone injury
tendon/ligament injury
trauma
rash
hair loss
nail changes
acne
mole changes
poor wound healing
TB history/ exposure
prolonged bleeding
easy bruising
blood transfusion
blood clots
swollen lymph nodes
food allergy: _____

seasonal allergy
bee sting allergy
other allergy: _____
itchy/watery eyes
frequent sneezing
swollen tongue
mood swings
constant hunger or thirst
increased appetite
darkening of skin
sex with women
sex with men
number of sexual partners:_____
history of sexually transmitted infection (ie herpes, chlamydia, gonorrhea, HIV, HPV)___
hopelessness/sadness
thoughts of hurting myself
suicide attempt
anxiety
nervousness
stress
depression
pain with intercourse
low sex drive
testicular mass/swelling/pain
difficulty with erections
penile discharge or pain, ulcers, growths
nipple discharge
heavy menses
menstrual cramps

The information I have provided on these forms is both truthful and accurate.



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Signature: _____ Date: _____

Office use only: HealthHistoryforPatientAAAC100323.docx



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