BLOOM
HEALTH & WELLNESS

# PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

**MEDICAL HISTORY**

**Allergies (Medications/Environmental/Food):** **Reaction:**

1._____ _____

2. _____ _____

3. _____ _____

**Medications**: ☐ See Attached List **Use back of paper if needed for additional medications

| Name of Medication: | Dose: | Frequency: |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

Pharmacy Name:_____City:_____State: _____

**Medical Problems (current or past):**

**Eye Condition:**
☐ Dry Eye ☐ Blindness
☐ Glaucoma ☐ Cataract
☐ Macular degeneration

**Ears/Nose/Throat:**
☐ Allergies/sinus ☐ hearing loss
☐ Nasal congestion
☐ nose bleeding

**Neurological:**
☐ Seizure ☐ Migraine ☐ Tremors
☐ Alzheimer ☐ Parkinson's

**Cardiac/Heart:**
☐ Heart attack ☐ Stroke
☐ CHF ☐ Hypertension
☐ Murmur ☐ Chest pain
☐ Palpitations

**Lung**:
☐ Asthma ☐ COPD
☐ Short of Air ☐ Tuberculosis
☐ Pneumonia ☐ Wears Oxygen
☐ Sleep Apnea

**Gastro/GI:**
☐ Acid Reflux ☐ Nausea/Vomit
☐ constipation/diarrhea
☐ Hemorrhoids/rectal bleeding
☐ Liver disease ☐ Hx diverticulitis

**Urinary**:
☐ Chronic kidney disease
☐ Freq UTI ☐Difficult urinating
☐ Hx kidney stones

**Endocrinology:**
☐ Diabetes ☐ thyroid disease
☐ Pituitary disease
☐ Parathyroidism ☐ Adrenal

**Mental Health:**
☐ Anxiety ☐ Depression
☐ ADHD ☐ Mood Disorder
☐ PTSD ☐ Schizophrenia

**Hematology:**
☐ Anemia ☐ Bleeding issues
☐ Hx of blood clot
☐ Leukemia/blood cancer

**Female Reproductive health:**
☐ Hx of pregnancy ☐ Never pregnant
☐ Abnormal periods ☐ PCOS
☐ Menopause ☐ Hx STD

**Rheumatology**:
☐ Psoriasis ☐ Chron's ☐ Lupus
☐ Rheumatoid arthritis
☐ Fibromyalgia ☐ Vasculitis
☐ Raynaud's ☐ Hashimoto's
☐ Ehlers-Danlo ☐ Sjogren's

**Chronic pain:**
☐ Back pain ☐ Arthritis
☐ Prior injury

**Male Reproductive health:**
☐ Hx STD ☐ Erectile Dysfunction
☐ Low testosterone ☐ Prostate issue

**Significant Family Hx:** **Include only 1st degree relatives (Mom, Dad, Brother, Sister)

☐ Cancer
Type: _____

☐ Heart Disease (heart attack, Stroke, high b/p, high cholesterol

☐ Diabetes

☐ Bleeding disorder

☐ Autoimmune disease

☐ COPD/lung issues

**Surgical History:**

| Procedure: | Year: | Location/Hospital: |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

****If you have an implantable device please provide a copy of the implant card.**
**Examples include pacemaker/defib, bladder stimulator, pain stimulator, infusion port, etc**

**Social History:**

Smoke: ☐ Never ☐ Quit ☐Yes
# of years: _____
# per day: _____

Alcohol: ☐ No ☐ Yes
☐ Daily ☐ Weekly ☐ Monthly
# drinks: _____

Drug Use: ☐ No ☐ Yes
What: _____
How often: _____

Exercise routinely:
☐ No ☐ Yes -- _____ x wk

Healthy Diet: ☐ No ☐ Yes

Regular Caffeine/Energy Drinks:
☐ No ☐ Yes

**Immunizations**:

☐ Up to date for age
☐ Unsure of vaccine status

**If available, please provide immunization records**

Pneumonia: ☐ No ☐ Yes
Year of last:_____

Shingles: ☐ No ☐ Yes
Year of last:_____

Tetanus: ☐ No ☐ Yes
Year of last: _____

Received any COVID vaccines:
☐ No ☐ Yes

Do you typically get a seasonal flu shot:
☐ No ☐ Yes

Ever had a bad reaction to any immunization: ☐ No ☐ Yes Reaction: _____
Hx of ☐ Guillain-Barré syndrome OR ☐ myasthenia gravis **AFTER** vaccine? ☐ N/A

| Wellness Screening | N/A | Date of last exam | Location | Results Normal | Results Abnorm |
|---|---|---|---|---|---|
| Colonoscopy: | ☐ | _____ | _____ | ☐ | ☐ |
| Mammogram: | ☐ | _____ | _____ | ☐ | ☐ |
| DEXA scan: | ☐ | _____ | _____ | ☐ | ☐ |
| Female pap: | ☐ | _____ | _____ | ☐ | ☐ |
| Lung Screening: | ☐ | _____ | _____ | ☐ | ☐ |
| Dental Exam: | ☐ | _____ | _____ | Denture | Partial |
| Eye Exam: | ☐ | _____ | _____ | Glasses | Contacts |

**Did you have a previous primary care provider: ☐ Yes ☐ No If yes, name:** _____

Please list any other healthcare providers that you are actively receiving care from (specialist/dentist/eye):

_____

_____

_____

_____

Other Pertinent Medical Information you would like to share with us?

_____

_____

_____

_____

Thank you for taking the time to complete your medical history. Providing an accurate and complete medical history will help Bloom Health & Wellness be able to provide the best care possible for you. If you have any important documents or records that you would like Bloom Health & Wellness to add to your chart you are welcome to provide copies to one of the staff members.

Patient Signature:_____ Date: _____

Parent/Guardian: _____ Date: _____