PINNER CLINIC, PA
PATIENT HEALTH ASSESSMENT

Patient Name (PLEASE PRINT): _____

Today's Date: _____ **DOB:** _____ **SS#:** _____

DRUG ALLERGIES: Please list ALL medications you are allergic to.

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

PREVIOUS MEDICAL ILLNESSES: Please check any illnesses you have had in the past.

- ☐ Anemia / Low Blood
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding from Bowels
- ☐ Bleeding Problems, Type: _____
- ☐ Blood Clot in Leg
- ☐ Blood Clot in Lung
- ☐ Blood Transfusion
- ☐ Cancer, Type: _____
- ☐ Communicable Disease, Type: _____
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes / High Blood Sugar
- ☐ Emphysema / Chronic Bronchitis
- ☐ Epilepsy / Seizures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irregular Heart Beat
- ☐ Kidney Disease, Type: _____
- ☐ Kidney Stones
- ☐ Prostate Problems
- ☐ Rheumatic Fever
- ☐ Skin Disease, Type: _____
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers in Bowels / Stomach
- ☐ Varicose Veins or Spider Veins
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

SURGICAL HISTORY: Please provide dates for any surgeries you have had.

SURGERY	DATE
Back Disc Surgery	
Abdominal Surgery	
Tonsils Removed	
Prostate Surgery	
Vasectomy	
Tubal Ligation	
Hysterectomy (Complete? □ Y □ N)	
Mastectomy □ R □ L	
Other: _____	

SURGERY	DATE
Appendectomy	
Joint Scope Surgery	
Biopsy	
Open Heart Surgery	
Neck Artery Surgery	
Cataract Surgery □ R □ L	
Gallbladder	
Broken Bone Repair	
Joint Replacement	

PATIENT HEALTH ASSESSMENT

Patient Name (PLEASE PRINT): _____

CURRENT MEDICATIONS: Please list ALL medications you are currently taking. Include dosage and how often you take each medication.

MEDICATION (including over-the-counter)	DOSAGE	HOW OFTEN DO YOU TAKE?

IMMEDIATE FAMILY HISTORY: Check beside any disease that has affected your mom, dad, brothers, and/or sisters.

☐	Heart Attack
☐	High Blood Pressure
☐	High Cholesterol
☐	Asthma
☐	Tuberculosis
☐	Liver Disease
☐	Kidney Disease

☐	Osteoporosis
☐	Stroke
☐	Epilepsy / Seizures
☐	Bleeding Problems
☐	Sickle Cell Anemia
☐	Diabetes / High Blood Sugar
☐	Thyroid Problems

☐	Cancer, Type:
☐	Alcohol Abuse
☐	Anxiety or Depression
☐	Glaucoma
☐	Other:
☐	Other:
☐	Other:

SPECIALISTS YOU ARE CURRENTLY SEEING:

Specialty	Specialist's Name	Location/Address	Phone Number

CURRENT HEALTH HABITS:

How often do you exercise? ☐ Never ☐ Occasionally ☐ Several Times Per Week ☐ Every Day

Have you ever smoked? ☐ Yes ☐ No	Number of Years: _____	How much do you/did you smoke every day? ____ # Cigarettes ____ # Packs

Do you use any of the following tobacco (other than cigarettes)?

☐ Pipe ☐ Snuff ☐ Cigars ☐ Chewing Tobacco ☐ Dip ☐ Electronic Cigarettes ☐ Vapor

Patient Name (PLEASE PRINT): _____

Females ONLY:

Are you pregnant or planning to be pregnant soon? ☐ Yes ☐ No

Currently breast feeding? ☐ Yes ☐ No

Number of: Pregnancies? ____ Miscarriages? ____ Deliveries? _____

Have you ever had postpartum depression? ☐ Yes ☐ No ☐ Not Sure

Current form of birth control: _____

Date of most recent: Pap smear? _____ Mammogram? _____ **Any abnormal results?**_____

Date of most recent menstrual period: _____