BluMine Health

HEALTH HISTORY

Patient Name: _____ **Date of Birth**: _____**Age:** _____
(Please Print: First, Middle Initial, Last Name of patient)

Social Security Number: _____ Name of Emergency Contact: _____

Emergency Contact Telephone Number: _____ Relationship to Emergency Contact: _____

Do you have Health Insurance? Yes _____ No _____ Insurance Policy Holder Name: _____

Primary Care Physician Name: _____ Pharmacy Name and Phone: _____

Sex: ☐Male ☐Female ☐Transgender **Status:** ☐Single ☐Married ☐Other

Ethnicity: Hispanic or Latin _____ Not Hispanic or Latin _____ Decline to Answer _____

Race:
☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Hispanic
☐Native Hawaiian or Other Pacific Islander
☐White
☐Other: _____
☐Decline to Answer

Language Preference: ☐English ☐Spanish ☐Other: _____

Are you allergic to latex? Yes _____ No _____ Other Allergies: _____

MEDICATION ALLERGIES:	**REACTION TO MEDICATION:**

MEDICATION LIST: Please List any PRESCRIPTION, OVER THE COUNTER MEDICATION OR VITAMINS

MEDICATION	DOSE	HOW OFTEN	WHY ARE YOU TAKING?

(If you need additional space, please use the back of this form to add any other medications.)

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Please check all that apply, about you personally, that you are experiencing now or have in the past, to the best of your knowledge so that we know how to best treat you. If you need additional help filling out this form, our staff will be happy to assist you.

General:	**Now**	**Past**	**Throat/Mouth:**	**Now**	**Past**	Change in appetite	**Now**	**Past**	High cholesterol/Lipids	**Now**	**Past**
Weight loss/gain	☐	☐	Bleeding	☐	☐	Change in bowel habits	☐	☐	High/Low Blood Pressure	☐	☐
Fatigue	☐	☐	Dentures	☐	☐	Rectal Bleeding	☐	☐	**Neurologic:**		
Fever/Chills	☐	☐	Sore tongue	☐	☐	Constipation	☐	☐	Dizziness/Fainting	☐	☐
Weakness	☐	☐	Dry Mouth	☐	☐	Diarrhea	☐	☐	Seizures	☐	☐
Trouble sleeping	☐	☐	Sore throat	☐	☐	Last Colonoscopy?	☐	☐	Weakness	☐	☐
Skin:			Hoarseness	☐	☐	Abdominal Pain	☐	☐	Numbness/Tingling	☐	☐
Rashes	☐	☐	Thrush	☐	☐	**Urinary:**			Tremors	☐	☐
Dryness	☐	☐	Non healing sores	☐	☐	Frequent urination	☐	☐	**Hematologic:**		
New Mole/Color changes	☐	☐	Lumps	☐	☐	Burning/painful urination	☐	☐	Bruise easily	☐	☐
Hair or nail changes	☐	☐	Swollen Glands	☐	☐	Blood in urine	☐	☐	Clot easily	☐	☐
Head:			Neck Pain	☐	☐	Incontinence	☐	☐	Hepatitis	☐	☐
Headache/Migraines	☐	☐	Stiffness	☐	☐	Other	☐	☐	**Endocrine:**		
Head injury	☐	☐	**Breasts:**			**Vascular:**			Heat or cold intolerance	☐	☐
Neck pain	☐	☐	Lumps	☐	☐	Calf pain w/walking	☐	☐	Sweating	☐	☐
Ears:			Pain	☐	☐	Leg cramping	☐	☐	Frequent Urination	☐	☐
Hearing loss	☐	☐	Discharge	☐	☐	Vein changes	☐	☐	Thirst	☐	☐
Ringing in ears	☐	☐	Self-exams	☐	☐	**Musculoskeletal:**			Diabetes	☐	☐
Ear pain	☐	☐	Date of Last Mammogram?			Muscle or joint pain	☐	☐	**Nose:**		
Drainage	☐	☐	**Respiratory:**			Osteoporosis	☐	☐	Discharge	☐	☐
Eyes:			Asthma	☐	☐	Broken bones	☐	☐	Nosebleeds	☐	☐
Vision change/loss	☐	☐	Coughing up blood	☐	☐	**Cardiovascular:**			Pressure	☐	☐
Redness	☐	☐	Wheezing	☐	☐	Chest pain/ discomfort	☐	☐	Itching	☐	☐
Blurry/double vision	☐	☐	Painful breathing	☐	☐	Tightness in chest	☐	☐	**List Other Symptoms:**		
Flashing lights	☐	☐	Other	☐	☐	Palpitations/ murmurs	☐	☐		☐	☐
Date of last Eye exam?			**Gastrointestinal**			Shortness of breath w/ activity	☐	☐		☐	☐
Itching	☐	☐	Difficulty Swallowing	☐	☐	Swelling in ankles	☐	☐		☐	☐

SURGERIES AND HOSPITALIZATIONS: **DATE:**

(If you need additional space, please use the back of this form to add any other surgeries or hospitalizations.)

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SOCIAL HISTORY:

Alcohol Use:
Do you drink alcohol? Yes ____ No _____ If Yes, number of drinks per week: _____
Alcohol problems in the past? Yes _____ No _____

Cigarette/Tobacco Use:
Do you smoke cigarettes? Yes _____ No _____ Never _____
If Yes, how long have you smoked? _____
If Yes, how many packs a day do you smoke? _____
Do you smoke/use: Pipe _____ Cigar _____ Snuff _____ Chewing Tobacco _____

Drug Use:
Do you use any recreational or illegal drugs? Yes _____ No _____
Have you ever used needles to inject drugs? Yes _____ No _____

Physical Activity:
Do you engage in any form of regular physical activity/exercise (at least 3 days per week)?
Yes _____ No _____

FAMILY HISTORY:
Please check all family history health conditions, both currently and in the past, to the best of your knowledge so that we know how to best treat you.

CONDITION	Mother	Father	Brother/Sister	Grandparents
Cancer				
High Blood Pressure				
Stroke				
Heart Disease				
Diabetes				

Please LIST any other medical conditions that run in your extended family. _____
_____

X Signature: _____ **Date:** _____
Patient/Parent/Legal Guardian Signature

If Patient is a Minor (under 18):

Print Name Parent/Guardian: _____ Relationship to Minor: _____