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: ☐ Native Hawaiian or Other Pacific Islander: _____
Asian: ☐ White: _____
Black or African American: ☐ Other: _____
Hispanic: _____ 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.)

Patient Name: _____ **Date of Birth**: _____

(Please Print: First, Middle Initial, Last Name)

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.)

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

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: _____