

Hopkins Clinic
Confidential Patient Information

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Welcome to **HOPKINS CLINIC**. **Help us help you by completing this form. Please answer all the questions completely. All information provided is strictly confidential.** If you do not understand a question or are unsure of the information, please ask for assistance.

HEALTH HISTORY FORM

Name: _____ Age _____ Date of Birth ____/____/____

Do you have a **Primary Care Doctor**? Dr. _____ Phone? _____

May we request and / or send information to the above-mentioned healthcare providers in order to make them aware of your progress and keep your records updated? **NO** ____ **YES** ____

Have you had or now have:

chronic fatigue__	stroke__	gas problems__	osteo arthritis__	numbness__
visual problems__	vascular disease__	vomiting__	rheumatoid arth.__	tingling__
sinusitis__	swollen ankles__	constipation__	gout__	depression__
ear aches__	asthma__	diarrhea__	swollen joints__	anxiety__
pain swallowing__	emphysema__	rectal bleeding__	rashes__	bipolar__
headaches__	short of breath__	liver disease__	psoriasis__	diabetes__
migraines__	lung problems__	kidney disease__	bruise easily__	thyroid problem__
heart disease__	tuberculosis__	bladder problem__	melanoma__	anemia__
chest pain__	ulcers__	menstrual problem__	cancer__	allergies__
hypertension__	stomach pain__	prostate problem__	epilepsy__	immune problem__

____ **NONE OF THE ABOVE**

MEDICAL ALLERGIES? (Penicillin, sulfur, etc?) **No / Yes** (Please list) _____

Food or environmental allergies? _____

Are you regularly taking **over the counter** medications? ___No ___Yes **Please circle:** Vitamins Aspirin Tylenol Advil Aleve Antacids Laxative Allergy Sleep-aids Other: _____

Are you taking **Cortico-Steroids**? **No** ____ **Yes** ____ For what condition? _____

Are you regularly taking **prescription medications**? **No** ____ **Yes** ____ **For what condition?**

Allergy__	Birth control__	Depression__	Immune system__	Headaches__
Antibiotics__	Blood Pressure__	Diabetes__	Kidney problem__	Migraines__
Anxiety__	Cholesterol__	Heart Disease__	Osteoporosis__	Clotting__
Asthma__	Chronic Pain__	Hormones__	Indigestion__	Epilepsy__

Please list names and dosage of medications: _____

Do you have any **intolerances or side effects** from any medications such as gas, nausea, gastritis, constipation, hives, etc.)? ___None _____

List any **SURGERIES** and the date of the surgery. ___None _____

List **broken bones**? **None** ____ **Yes** ____ What and when? _____

Any **serious illnesses**? **No / Yes** If yes, what and when? _____

Please list any **hospitalizations**, for what reason and what year: None

List any **previous car or work related accident / injury**? No Yes... If yes, give date and briefly describe:

Are you?... Single Married Separated Divorced Widowed

If **employed**, briefly describe your **occupation**: _____

Are you exposed to any **hazardous substances**? **Yes / No** List: _____

Do you perform any **heavy lifting**? **Yes / No** Describe: _____

If no longer working, **when and why did you stop**? _____

Do you use **tobacco**? Yes___ No___ Cigarettes: ___pack per day for ___ years; Other _____

Do you drink **alcohol**? Yes___ No___ Daily___ Weekly___ Socially___ Rarely___

Do you drink **coffee**? Yes___ No___ Cups per day _____ Drink **cola**? Yes___ No___ Cans per day _____

Please list **pregnancies**: None

Year of birth	Sex of birth	Complications if any

Please list any diseases or cause of death for the following family members:

Relation	Age	State of health	Age at death	Cause of death	Check (✓) if your blood relatives had any of the following diseases (relationship to you)
Father					<input type="checkbox"/> arthritis, gout
Mother					<input type="checkbox"/> asthma, emphysema
Brothers					<input type="checkbox"/> cancer
					<input type="checkbox"/> chemical dependency
					<input type="checkbox"/> diabetes
Sisters					<input type="checkbox"/> heart disease, stroke, high blood pressure
					<input type="checkbox"/> kidney disease
					<input type="checkbox"/> tuberculosis

Please tell the doctor about any other concerns not listed above. Use the space below to write about any other concerns you may have. Thank you and Welcome to Hopkins Clinic!
