SHAPE Medical Center
Stroke, Heart Attack Prevention and Education

Health History

Legal Name:_____ Date:_____ DOB:_____

Your answers will give us a better understanding of your medical concerns and conditions. Please be as specific and honest as you can, as this will enable us to give you the best comprehensive treatment. Please contact family members if you need assistance completing the family history section. If you need more space, simply attach as many additional pages as you need. Please take your time and complete all pages. THANK YOU!

How would you rate your current health? (Please circle one). Excellent Good Fair Poor

Current age:_____ Wt:_____ Ht:_____ Ethnicity:_____

Waist measurement:_____ Date of your last physical exam:_____

Medications: Please list all prescription and non-prescription medications, vitamins, home remedies, and herbs.

Medication/Supplements	*Dose (milligrams per pill, does per day)*	*Start Date*	*Reason*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please use back of form if you need additional space.

Allergies or reactions to medicines:_____
_____
Food Allergies:_____

When was your most recent:
ABI (ankle brachial index)_____ Cholesterol Screening_____
Chest X-ray_____ EKG_____ IMT_____
Bone Density Test_____ Flu Vaccine_____ Shingles Vaccine_____
Pneumovax_____ Dental Exam_____ Eye Exam_____
Coronary CT Scan_____ Any other vascular test, please specify:_____
_____

Personal Medical History *Please indicate whether you have had any of the following medical problems (include **dates** to indicate when the problem occurred).*
Heart Disease_____ Bleeding/Clotting Problems_____

Alcoholism_____ Rheumatoid Arthritis_____
Gout_____ Aortic Aneurysm_____
High Blood Pressure_____ Blood Transfusion_____
Polycystic Ovaries_____ High Cholesterol_____
Cancer (Malignancy)_____
Skin Cancer (specific types)_____
Depression/Suicide Attempts_____ Diabetes (specific type)_____
Unexplained Nerve Problems (specify type)_____
Poor Blood Flow To Extremities_____
Other Medical Problems(specify)_____
Have you ever had a **serious injury** or been hospitalized for **illness**? YES NO If yes, please tell us When and Why:_____
_____
Have you ever had the following procedures? If so, please list the dates:
Coronary Artery Bypass Surgery_____ Angioplasty or Stent_____

Surgical History

Please list all other **operations** with the dates when they occurred:
_____
_____
_____
_____

Social History

Tobacco Use

Cigarettes Never_____ Cigarettes Quit (date you quit smoking)_____
Current Smoker (number of packs per day)_____
Other Tobacco *(circle all answers that apply)*: Pipe Cigar Chewing Tobacco
Number of years you've used this tobacco_____
Are you interested in quitting? YES NO Have you tried to quit in the past? YES NO
Are you exposed to second-hand smoke? YES NO For How Long?_____

Alcohol Use

Do you drink alcohol YES NO If yes, how many drinks do you consume per week?_____
Alcohol type_____
How many times in the past 3 months have you consumed more than 4 drinks (women) 5 drinks (men) in one day?_____
Does your alcohol consumption have you or others concerned? YES NO

Drug Use

How many times in the past year have you used an illegal drug or taken a prescription medication for nonmedical reasons? Please circle: never 1-2 3-9 10+

Weight

Are you satisfied with your weight? YES NO What is your goal weight?_____
When did you last weigh your goal weight?_____ How long were you at that weight?_____

Exercise

Do you exercise regularly? YES NO
What kind of exercise?_____
How long do you exercise (in minutes)_____ How often?_____
If you do not exercise, why not?_____

Socioeconomics

Occupation_____ Employer_____

Years of education/highest degree_____Marital Status (circle one) S M D W

Spouse/partner's name_____

Who lives at home with you?_____

How many children do you have? (Please provide names, gender, and ages)

_____

_____

Stress

How would you classify your stress level at work? (Please circle one) Low Med High

How would you classify your stress level at home? Low Med High

Do you often feel anxious, angry, irritated or rushed? NO YES

How do you manage your stress?_____

Nutrition

How do you rate your diet? (Please circle one) Good Fair Poor

What do you like about your current diet?_____

What don't you like about your current diet?_____

Do you have concerns about your nutrition?_____

Do you take dietary supplements? If so, please list them:_____

Why do you takes these supplements?_____

On a scale of 1-10, how willing are you to change your nutritional intake? (10 being **very** willing) _____

What are your barriers to a healthy diet?_____

Is your grocery budget a factor? YES NO What is your grocery budget per month?_____

How many daily servings of the following do you typically have? Use yesterday as an example:

Whole Grains_____ In what form?_____

Fruits_____ What are some of your most common_____

Vegetables_____ What are some of your most common?_____

Do you know how many servings of fruits and vegetables you should be consuming for optimal health?

(Please Circle) 1-3 4-6 7-9 9-13+

How many times in one week do you consume the following items?

Eggs____ Fish____ Chicken/turkey____ Red meat____ Butter____ Margarine____ Milk____

Ice Cream____ Other high fat dairy products?____ Other low fat diary products?____

Fried Foods____ Hard Candy____ Do you add table salt to your food? YES NO

Do you add sugar to your cereal? YES NO

Caffeine Intake

Coffee_____cups/day Cream? Y N Sugar? Y N Tea_____cups/day

Cream? Y N

Sugar? Y N Sodas per day_____ Diet Regular (circle one)

Sweetened Iced Tea/Lemonade/Sports Drinks, etc per day_____

Chocolate_____ounces per day (circle one) Dark Light

Do you snack between meals? Y N On What?_____

Do you eat past 8pm? Y N What?_____

What type of cooking oil(s) do you use?_____

Who prepares meals at home?_____Who buys the food for home?_____

How often do you eat out?_____/per week Where?_____

History For Women

How many times have you been pregnant?_____ How many deliveries_____ Miscarriages_____
Please list any problems you have experienced with pregnancy or delivery_____
_____
Do you have osteoporosis (bone loss)? YES NO Osteopenia (bone thinning)? YES NO
When was the first day of your most recent period?_____
What was your age at your first period?_____ Frequency of periods_____ Length of each_____
Regular or Irregular? Menopause? YES NO Hysterectomy? YES NO When_____
Ovaries removed? YES NO Do you have any history of gestational diabetes? YES NO
High blood pressure or eclampsia with pregnancy? YES NO
Did any of your children weigh more than eight pounds at birth? YES NO

Review of Symptoms

Please check any current problems you have on the list below:

Constitutional:
_Fever/chills/sweats
_Unexplained weight loss/gain
_Brittle nails
_Dry skin
_Change in skin texture
_Change in hair texture
_Inability to stand heat
_Inability to stand cold
_Change in energy/increased weakness
_Excessive thirst or urination

Respiratory:
_Cough/wheeze
_Difficulty breathing
_Snoring
_Sleep apnea/CPAP

Eyes:
_Change in vision (explain)_____

Ear/Nose/Throat/Mouth
_Difficulty hearing/ringing in your ears
_Hay fever/allergies
_Problems with teeth/gum

Cardiovascular:
_Chest pain/discomfort
_Palpitations (irregular heart beat)
_Swelling in feet or legs _Varicose veins _Pain in extremities

Neurological:
_Headaches (frequency)_____
_Light-headedness
_Memory loss
_Loss of coordination
_Tingling, pain, numbness in hands or feet
_Restless leg

Psychiatric:
_Problems with sleep
_Depression
_Panic attacks
_Mania
_Anxiety
_Anger issues

Blood/Lymphatic:
_Easy bruising/bleeding
_Unexplained lumps

Sexual:
_Problems with erectile function

Gastrointestinal:
_Abdominal
_Diarrhea/constipation
_Blood in bowel
_Heartburn
_Nausea

PHYSICIAN/PROVIDER INFORMATION FORM

Your Primary Care Provider:_____
Specialty:_____
Last Visit:_____ Frequency of Visits:_____
Telephone:_____ Fax:_____
Address:_____

Other Attending Provider:_____
Specialty:_____
Last Visit:_____ Frequency of Visits:_____
Telephone:_____ Fax:_____
Address:_____

Other Attending Provider:_____
Specialty:_____
Last Visit:_____ Frequency of Visits:_____
Telephone:_____ Fax:_____
Address:_____

Other Attending Provider:_____
Specialty:_____
Last Visit:_____ Frequency of Visits:_____
Telephone:_____ Fax:_____
Address:_____

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