CAPSTONE
MEDICAL ASSOCIATES

4807 Jonestown Road, Suite 141, Harrisburg PA 17109

~ Health History Form ~

Patient Name:____

Today's Date:____________________ Date Of Birth: ____________________

Symptoms:

Review of Systems: ("X" all that you have experienced in the past year)

General:
- ☐ Loss of appetite
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fatigue

Eyes:
- ☐ Double vision
- ☐ Discharge/drainage
- ☐ Flashing lights
- ☐ Blurry vision
- ☐ Itching

ENT - Ears, Nose, Throat:
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Post nasal drip
- ☐ Runny nose
- ☐ Change in smell
- ☐ Dental problems
- ☐ Hoarse voice
- ☐ Pain / Difficulty swallowing
- ☐ Sore throat

Cardiovascular:
- ☐ Chest pain / tightness
- ☐ Swelling of ankles
- ☐ Fainting spells
- ☐ Palpitations
- ☐ Leg pain with walking / exercise

Respiratory:
- ☐ Cough
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Wheezing

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Belching
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/Bloating
- ☐ Heartburn
- ☐ Blood in stool
- ☐ Black or tarry stool
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting

Genito-Urinary:
- ☐ Pain / Burning with urination
- ☐ Blood in urine
- ☐ Trouble starting urination
- ☐ Getting up at night to urinate
- ☐ Frequent urination
- ☐ Frequent bladder infections

Musculoskeletal:
- ☐ Joint pain
- ☐ Muscle cramping
- ☐ Muscle aches
- ☐ Back pain
- ☐ Neck pain
- ☐ Joint stiffness / swelling
- ☐ Muscle weakness

Patient Name:____

Symptoms (continued):

Skin / Hair / Nails:

- ☐ Bruising
- ☐ Dryness
- ☐ Hives
- ☐ Itching
- ☐ Rashes
- ☐ Abnormal hair growth
- ☐ Hair loss
- ☐ Brittle nails
- ☐ Cracking nails
- ☐ Pitting nails

Neurologic:

- ☐ Trouble walking
- ☐ Difficulty concentrating
- ☐ Confusion
- ☐ Dizziness
- ☐ Headaches
- ☐ Lightheadedness
- ☐ Memory loss
- ☐ Numbness / tingling
- ☐ Drowsiness
- ☐ Tremors

Psychiatric:

- ☐ Agitation
- ☐ Anxious
- ☐ Frequent crying
- ☐ Hallucinations
- ☐ Insomnia
- ☐ Loss of interest
- ☐ Mood changes
- ☐ Suicidal thoughts
- ☐ Stress

Endocrinologic:

- ☐ Hot flashes
- ☐ Night sweats
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Ankle swelling

Hematologic / Lymphatic:

- ☐ Swollen lymph nodes / glands
- ☐ Easy / excessive bruising
- ☐ Easy / excessive bleeding
- ☐ Tender lymph nodes / glands

Men:

- ☐ Erection difficulties
- ☐ Low libido (sex drive)
- ☐ Lump in testicles
- ☐ Discharge from penis
- ☐ Sores on penis
- ☐ Date of last prostate exam____________________

Women:

- ☐ Irregular periods
- ☐ Low libido (sex drive)
- ☐ Lump in breasts
- ☐ Excessive menstrual bleeding
- ☐ Excessive menstrual cramping
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Date of last PAP test_________________________
- ☐ Date of last mammogram_____________________

Past Medical History

Patient Name: ____

Please “X” all symptoms/conditions that you currently have or have had in the past year.

- □ Acid Reflux
- □ AIDS / HIV
- □ Alcoholism
- □ Anemia
- □ Anorexia Nervosa
- □ Arthritis
- □ Asthma
- □ Bulimia
- □ Cancer
  Type:________________________________
- □ Cataracts
- □ Diabetes
- □ Diverticulosis
- □ Drug Abuse
- □ Emphysema
- □ Epilepsy / Seizure Disorder
- □ Glaucoma
- □ Gout
- □ Heart Disease
- □ Hemophilia
- □ Hepatitis
- □ High Cholesterol
- □ High Blood Pressure
- □ Irregular Heart Beat
- □ Kidney Disease
- □ Kidney Stones
- □ Liver Disease
- □ Macular Degeneration
- □ Migraine Headaches
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Peripheral Vascular Disease
- □ Pneumonia
- □ Polio
- □ Prostate Disease
- □ Psychiatric Illness
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Seasonal Allergies
- □ Stomach Ulcers
- □ Stroke
- □ Thyroid Disease
- □ Tuberculosis
- □ Venereal Disease

Serious Accidents / Injuries:

- □ Head injuries / concussions
- □ Broken bones
- □ Gunshot / knife wounds
- □ Lacerations
- □ Motor Vehicle Accidents
- □ Work-related injuries

Past Surgical History: (Please list & date, if remembered)

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Patient Name: ____

Blood Transfusions? Yes / No If yes, What year?______________________________

Family History

Father: Alive / Deceased Age: ____________________

Medical Conditions: ____

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If deceased, cause of death: ____

Mother: Alive / Deceased Age: ____________________

Medical Conditions: ____

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If deceased, cause of death: ____

Number of siblings: ________________ Brothers: _______________ Sisters: ________________

Brothers:
1: Alive / Deceased Age:_________ Medical Conditions:______________________________
2: Alive / Deceased Age:_________ Medical Conditions:______________________________
3: Alive / Deceased Age:_________ Medical Conditions:______________________________
4: Alive / Deceased Age:_________ Medical Conditions:______________________________
5: Alive / Deceased Age:_________ Medical Conditions:______________________________

Sisters:
1: Alive / Deceased Age:_________ Medical Conditions:______________________________
2: Alive / Deceased Age:_________ Medical Conditions:______________________________
3: Alive / Deceased Age:_________ Medical Conditions:______________________________
4: Alive / Deceased Age:_________ Medical Conditions:______________________________
5: Alive / Deceased Age:_________ Medical Conditions:______________________________

Other Significant Family History: ____

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Patient Name:____

Social History

Status: (Please circle)

Single / Married / Separated / Divorced / Widowed / Significant Other

Occupation: ____

Exposure to Environmental Hazards? Yes / No

If yes, what?____

Tobacco use? Yes / No

If yes, what? ____

Quantity / Frequency: ____

Alcohol use? Yes / No

If yes, what? ____

Quantity / Frequency: ____

Drug use? Yes / No

If yes, what? ____

Quantity / Frequency: ____

Caffeine use? Yes / No

If yes, what? ____

Quantity / Frequency: ____

Medications / Allergies

Prescription Medications:
(Please list prescription medications you are taking)

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Vitamins/Herbal Supplements:
(Please list all supplements)

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Allergies:
(Please list all allergies)

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Preferred Pharmacy:

Local:____

Mail In:____

Name of Person completing this form:____

Signature:____Date:__________________________________