Premier Health
Premier Physician Network

Health History Questionnaire

Gem City Surgeons
Miami Valley Hospital North
9000 N. Main St., Ste. 233
Englewood, Ohio 45415
(937) 832-9310
(937) 832-8613 Fax

Atrium Medical Center
Professional Building
200 Medical Center Dr.
Ste. 250
Middletown, Ohio 45005

Today's Date: _____ Appt w/Doctor: _____ Referring Doctor: _____

Patient Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Reason For Appointment: _____

☐ Abnormal Mammogram ☐ Breast Cancer ☐ Routine Check-up ☐ Other: _____

Describe Current Illness:

Type of Symptoms: _____

Location of Symptons: _____

Length of Symptoms: _____

Tests Done/Where Done: _____

Past Medical History:

Heart Attack	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	Blood Clot Leg/Lungs	☐ Yes	☐ No
Irregular Heart	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Bleeding Disorders	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Acid Reflux	☐ Yes	☐ No
SleepApnea	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No
Kidney Failure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No	Migraines	☐ Yes	☐ No
			Seizures	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Hepatitis .	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Connective Tissue Disorders (Lupus,Scleroderma) Dyes	☐ Yes	☐ No

Cancer(type): _____

Other: _____

Female Patients:

Menstrual history: Age at onset: _____ Normal Cycle Length(days): _____ Date last period began: _____

Number of Pregnancies: _____ Number of Live Births: _____ Miscarriages: _____ Abortion _____

Age at Menopause: _____ Date LMP Began: _____ Date of Last Pap Smear: _____

Date of Last Mammogram: _____

S-C-PCP93713-6/2019

Previous Surgeries (Type, Surgeon, Hospital, Date):

_____ _____

_____ _____

_____ _____

_____ _____

_____

Current Medications & dose (including over the counter.and herbal medications):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____

Allergies and Type of Reaction:

_____ _____

_____

Social History:

☐ Tobacco Packs per day: _____ Number of Years: _____ When did you quit?: _____

☐ Alcohol Type of drink: _____ Number per week: _____ ☐ Recreational drugs Type: _____

☐ Profession/job: _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed

_____

Family History (has any family member had the following and who?):

Heart Attack: _____ High Blood Pressure: _____

Stroke: _____ Diabetes: _____

Cancer(type?): _____ Other: _____

_____

Review of Systems: (check all that apply)

☐ Chest Pain ☐ Diarrhea ☐ Difficulty Swallowing ☐ Leg Swelling

☐ Shortness of Breath ☐ Blood in Stool ☐ Night Sweats ☐ Abdominal Pain

☐ Abdominal Pain ☐ Problem Urinating ☐ Excessive Fatigue ☐ Nausea/Vomiting

☐ Weight Loss ☐ Back Pain ☐ Constipation ☐ Persistnt Cough ☐ Leg Pain

Patient Signature: _____ Date: _____

Reviewed by (MD Signature): _____ Date: _____

S-C-PCP93713-6/2019