James F. Hesse, MD; Kurt M. Hesse, MD: Diana R Crook, MD;
Jennifer J. Halabi, MD; Lynnette S. Jacobsen, MD
Diana C. Oltean, APRN
8020 E. Central Ave. Suite 200 □ Wichita, Kansas 67206 □ (316) 636-2662

HEALTH HISTORY FORM

Please complete both sides of this sheet to help your provider today

Today's Date: ____________________ Which Provider are you seeing today? ____________________

Patient Name: ____

Age: ________ Birthday: ____________ Occupation: ____________

Sex: Marital Status:

MAIN CONCERNS: What brings you in today?	How long has it been going on?
A.	
B.	
C.	

SURGERIES/HOSPITALIZATIONS	What type of illness/operation?	When?
A.		
B.		
C.		

PAST ILLNESSES: Please check any that apply.

Scarlet Fever	Unconciousness	Tuberculosis
Pneumonia	High Blood Pressure	Diabetes
Heart Attack	Rheumatic Fever	Chicken Pox
Allergy	Kidney Disease	Cancer
Anemia	Liver Disease	Asthma

FAMILY HISTORY: list age	Diseases	If Deceased, list age at death and cause
Mother		
Father		
Brother		
Sister		
Son		
Daughter		

Have any of your blood relatives had any of the following? (Please Circle)

Heart Disease	Stroke	Kidney Disease	Psychiatric Disorder	Tuberculosis
Cancer	Emphysema	Thyroid Disease	Congential Disease	Alzheimer's
Diabetes	Allergies	Osteoporosis	High Blood Pressure	

Are you adopted? ____________________

Would you like to discuss a Living Will and/or Medical Durable Power of Attorney with our staff? ______________

SOCIAL HISTORY:

Tobacco	☐ Never	☐ Used to	☐ Currently smoke ___________ per day.
Alcohol	☐ Never	☐ Used to	☐ Currently drink ___________ per week.
Substance Abuse	☐ Never	☐ Used to use	☐ Currently use ______________.
Caffeine	☐ No	☐ Currently drink ___________ ounces of caffeine per day.	
Fruits and Vegetables	☐ No	☐ Currently eat ___________ servings per day.	
Sexually Active	☐ No	☐ Currently active and use ________________ for family planning.	
Wear your Seatbelt	☐ No	☐ Always	
Regular Exercise	☐ No	☐ Currently _________________ (type) ___________ times per wk.	

MEDICATIONS Please list any MEDICATIONS you are currently taking, including supplements

1	4
2	5
3	6

MEDICATION ALLERGIES Please list the REACTION you experienced next to the drug.

1	4
2	5
3	6

REVIEW OF SYSTEMS (Check any that apply)

METABOLIC
Weight Change
Warmer/Colder than others
Increase sweating
Goiter
Increased thirst
Increased urination
Skin, hair or nails changed
Other:

RESPIRATORY
Short of breath
Wheezing
Productive cough
Bloody cough
Other:

HEAD/EYES/EARS/NOSE/THROAT
Headache
Hearing problem
Vision problem
Ear pain
Dizziness
Nasal drainage
Sore mouth or throat
Other:

ALLERGIES (NON-MEDICATION)
Hay fever
Asthma
Rashes/hives
Food allergies
Other:

CARDIOVASCULAR
Chest Pain
Rapid Heartbeat
Irregular Heartbeat
Ankle Swelling
High Blood Pressure
Calf Pain when walking
Other:

BLOOD/LYMPH
Bleeding
Bruising
Anemia
Enlarged Glands
Fever
Other:

URINARY
Bloody Urine
Urinary Frequency
Painful Urination
Burning Urination
Bladder Not Emptying
Leaky Bladder
Urinary Urgency
Other:

OTHER ISSUES
List any issues not already marked.

GASTROINTESTINAL
Heartburn
Nausea/Vomitting
Hard to Swallow
Abdominal Pain
Bloody Stools
Black Stools
Jaundice
Change in Bowels
Constipation
Diarrhea
Belching/Gas
Hemorrhoids
Other:

MIND AND BODY
Back Pain
Joint Pain
Neck Stiffness
Muscle Weakness
Paralysis
Tremors/Shakes
Numbness/Tingling
Convulsions
Fainting
Depression/Anxiety
Stress
Sleep Issues
Memory Loss
Trouble walking
Other:

FEMALE PATIENTS

Do you have Periods? ☐ No, my final period was ___________.
Yes, every _______ days for _________ days per period.
At what age was your first period? _________________________.
Have you been pregnant ☐ Never ☐ Yes, ______times.
How many live births? ____________
Any complications?
Do you take Calcium? ☐ No ☐ Yes

MALE PATIENTS

Impotence? ☐
Urine stream issues? ☐
Testicular exam? ☐
Scrotal lumps? ☐
Other Issues:

VACCINATED FOR

Tetanus ☐
Pneumonia ☐
Hepatitis B ☐
Flu ☐
MMR ☐
Shingles ☐
Other: