History English / Patient Intake

Healthline Medical Group
15211 Vanowen St. suite 105
Van Nuys, CA 91405
818-997-7711

Patient Name:

Birth Date: **Gender:**

Person Number: **MRN:**

Appt Date:

Past Medical History

Place an "X" in the appropriate box if you have ever been diagnosed with any of the following:

☐ Allergies	☐ Blood clots	☐ GERD	☐ Myocardial infarction
☐ Anemia	☐ COPD	☐ Gallbladder disease	☐ Osteoarthritis
☐ Angina	☐ Cancer	☐ Hepatitis C	☐ Osteoporosis
☐ Anxiety	☐ Cerebrovascular accident	☐ Hyperlipidemia	☐ Peptic ulcer disease
☐ Arthritis	☐ Coronary artery disease	☐ Hypertension	☐ Renal disease
☐ Asthma	☐ Crohn's disease	☐ Irritable bowel disease	☐ Seizure disorder
☐ Atrial fibrillation	☐ Depression	☐ Liver disease	☐ Stomach / Duodenal ulcer
☐ Benign prostatic hypertrophy	☐ Diabetes	☐ Migraine headaches	☐ Thyroid disease

Past Surgical History

Place an "X" in the appropriate box if you have ever had any of the following surgeries:

	Year		Year		Year
☐ Angioplasty		☐ Cholecystecotmy		☐ Liver biopsy	
☐ Angio w/stent		☐ Colectomy		☐ ORIF	
☐ Appendectomy		☐ Colostomy		☐ Pacemaker	
☐ Arthroscopic knee		☐ Gastric bypass		☐ Small bowel resection	
☐ Back surgery		☐ Hernia repair		☐ Thyroidectomy	
☐ CABG		☐ Hip replacement		☐ Tonsillectomy	
☐ Carpal tunnel release		☐ Knee replacement			
☐ Cataract extraction		☐ LASIK			

☐ Misc. Surgery 1 year: Type

☐ Misc. Surgery 2 year: Type

☐ Misc. Surgery 3 year: Type

Social History

Place an "X" in the appropriate box :

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life partner

Please continue on other side

Family History

Place an "X" in the appropriate box if any family members have been diagnosed with:

Has anyone in your immediate family ever had any of the following diseases? If so please select the disease(s).

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's disease
- ☐ Asthma
- ☐ Blood disease
- ☐ CAD
- ☐ CAD - premature
- ☐ Cancer
- ☐ CVA (stroke)
- ☐ Depression
- ☐ Developmental delay
- ☐ Diabetes
- ☐ Eczema
- ☐ Hearing deficiency
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Irritable bowel disease
- ☐ Learning disability
- ☐ Mental illness
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ PVD
- ☐ Renal disease
- ☐ Seizure disorder

Other family history:

What is your tobacco use history?

Smoker Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown ☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked

	Current	Former	Never	Amount per day:	Number of Years:
Cigarettes	☐	☐	☐	Packs	
Cigar	☐	☐	☐	Cigars	
Pipe	☐	☐	☐	Pipes	

	Current	Former	Never	Amount per day:	Number of Years:
Chewing	☐	☐	☐	Ounces	
Snuff	☐	☐	☐	Ounces	
Smokeless (Electronic)	☐	☐	☐	Units	

Second-hand smoke exposure: ☐ Yes ☐ No

What is your alcohol use history?

Drinks alcohol: ☐ Yes ☐ No ☐ Formerly

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Drinks caffeine: ☐ Yes ☐ No

Prior History of auto accidents, work or personal injuries.

Prior history of any auto accidents? ☐ Yes ☐ No

Prior history of any prior work related injuries? ☐ Yes ☐ No

Prior history of sports or personal injuries ? ☐ Yes ☐ No

Please place an X in any of the boxes listed below that represents prior or current treatment

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Chiropractic Treatment
- ☐ Acupuncture
- ☐ Surgery
- ☐ Injections
- ☐ Chronic Pain
- ☐ Permanent Work Restrictions
- ☐ MRI's or CT Scans

If yes, please provide details below: