Health Information Form

MARTHA STEWART CENTER for LIVING AT MOUNT SINAI

GENERAL INFORMATION

Name (Last) (First) (Middle)

Date of Birth

Address (Street)

City	State	Zip Code	Country

Home Phone	Work Phone
Cell Phone	E-mail

Preferred Method of Contact

Reason for Visit (select one)

- ☐ Establish Primary Care
- ☐ Consultation (specify reason and referring provider):
- ☐ Other (please specify reason):

Pharmacy

Name Phone number

Address

Advanced Directives (please bring copies)

- ☐ Health Care Proxy
- ☐ Living Will
- ☐ Other (please list):

Health Care Proxy Name: ☐ Same as emergency contact

Address

City	State	Zip	Country

Home Phone	Work Phone
Cell Phone	E-mail

EMERGENCY CONTACTS

Primary Contact

Name (Last) (First) (Middle)

Relation to Patient

Home Phone	Work Phone
Cell Phone	E-mail

Preferred Method of Contact

Secondary Contact

Name (Last) (First) (Middle)

Relation to Patient

Home Phone	Work Phone
Cell Phone	E-mail

Other Health Providers

Name	Specialty	Phone Number

Medications

Name	Dose	Frequency	Reason for Medication
I.			
II.			
III.			
IV.			
V.			
VI.			
VII.			
VIII.			
IX.			
X.			

Allergies

Medication	Food/Environment	Reaction
I.		
II.		
III.		
IV.		
V.		

Active Medical History

Medical Problem	How Long?	Doctor Treating
I.		
II.		
III.		
IV.		
V.		
VI.		

Past History

*Medical issues not mentioned in active problems.

Medical Problem	How Long?	Doctor Treating
I.		
II.		
III.		
IV.		
V.		

Surgery/Procedures

Procedure	Date	Doctor	Hospital	
I.				
II.				
III.				
IV.				
V.				

Social

I. Tobacco:

- ☐ Yes
- ☐ No
- ☐ Never
- ☐ Quit

Quit Date: _____
Packs per Day: _____
How long (years): _____
Type of Tobacco: _____

II. Alcohol:

- ☐ Yes
- ☐ No

Number of Drinks per week: _____
Type of Alcohol: _____

III. Other Drugs

- ☐ Yes
- ☐ No

Type: _____

IV. Sexually Active:

- ☐ Yes
- ☐ No

V. Currently Working:

- ☐ Yes
- ☐ No

VI. Work Experience:

_____

VII. Birthplace: _____

VIII. Primary Language: _____

IX. Preferred Language of Communication:

_____

X: Children:

- ☐ No
- ☐ Yes

#/Names:

XI: Assistance Required for:

- ☐ Finances/Bills
- ☐ Managing Medications
- ☐ Transportation
- ☐ Communication
- ☐ Shopping
- ☐ Cleaning
- ☐ Bathing
- ☐ Dressing
- ☐ Eating
- ☐ Toileting
- ☐ Transferring

XII : Help at Home

- ☐ No
- ☐ Yes

Type of help and hours per week

Health Maintenance and Immunizations

	Yes/No	Date	Any Abnormalities?
Bone Density (DEXA)			
Colonoscopy			
Eye Exam			
Mammogram			
Pap Smear			
Pneumovax (Pneumonia Vaccine 23)			
Prevnar (Pneumonia Vaccine 13)			
Podiatry (Foot Exam)			
Tetanus Vaccine			
Zoster Vaccine (Shingles)			
Flu Vaccine			
Dental Exam			

I. Do you exercise regularly? Type? Frequency?

_____

_____

Family Members' Health

List any Health Problems	Relationship(s) and Age(s) of Onset	Comments
I.		
II.		
III.		
IV.		
V.		

** IF DECEASED, INDICATE AGE AND CAUSE OF DEATH USING THE LINES BELOW.

_____

_____

_____

_____

Symptoms Review

Have you experienced any of the following in the past three months?

*** Check All That Apply***

- ☐ WEIGHT CHANGES
- ☐ DEPRESSION
- ☐ MEMORY LOSS
- ☐ FALLS

- ☐ LEAKAGE OF URINE
- ☐ HEARING LOSS
- ☐ VISUAL LOSS
- ☐ SLEEP DISTURBANCE
- ☐ FEVER/CHILLS

- ☐ VISUAL BLURRING
- ☐ DOUBLE VISION
- ☐ EYE PAIN
- ☐ BLIND SPOT
- ☐ ITCHY EYES

- ☐ RINGING IN THE EARS
- ☐ VERTIGO
- ☐ BLOODY NOSES
- ☐ DEVIATED SEPTUM
- ☐ FREQUENT RESPIRATORY INFECTIONS
- ☐ SINUS TROUBLE
- ☐ PERSISTENT SORE THROAT
- ☐ BLEEDING GUMS
- ☐ DENTAL PROBLEMS
- ☐ SINUSITIS
- ☐ HOARSE VOICE
- ☐ HEADACHE
- ☐ EAR PAIN
- ☐ JAW PAIN

- ☐ COUGH
- ☐ SHORTNESS OF BREATH
- ☐ PRODUCTIVE SPUTUM
- ☐ BLOOD IN SPUTUM
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH DURING EXERTION

- ☐ PALPITATIONS
- ☐ RACING HEART
- ☐ CHEST PAIN
- ☐ SWELLING
- ☐ DIZZINESS

- ☐ DIFFICULTY SWALLOWING
- ☐ PAINFUL SWALLOWING
- ☐ ABDOMINAL PAIN
- ☐ EXCESSIVE GAS/BLOATING
- ☐ BLOOD IN STOOLS
- ☐ CONSTIPATION

- ☐ DIARRHEA
- ☐ NAUSEA
- ☐ VOMITING
- ☐ ACID REFLUX/HEARTBURN

- ☐ FREQUENT NIGHTTIME URINATION
- ☐ URINARY FREQUENCY
- ☐ PAINFUL URINATION
- ☐ URINATION URGENCY
- ☐ ERECTILE DYSFUNCTION

- ☐ VAGINAL ITCHING/DRYNESS
- ☐ SPOTTING/DISCHARGE
- ☐ PAINFUL INTERCOURSE
- ☐ BREAST MASS
- ☐ NIPPLE DISCHARGE

- ☐ PAINFUL GAIT
- ☐ BACK PAIN
- ☐ BONE PAIN
- ☐ MUSCLE PAIN
- ☐ MUSCLE WEAKNESS
- ☐ FATIGUE
- ☐ JOINT PAIN OR SWELLING
- ☐ VARICOSE VEINS

- ☐ SKIN RASH
- ☐ ITCHING
- ☐ MASS

- ☐ FAINTING
- ☐ SEIZURES
- ☐ NUMBNESS OR TINGLING OF HANDS OR FEET
- ☐ TREMOR
- ☐ ROOM SPINNING
- ☐ LIGHTHEADEDNESS

- ☐ ANXIETY
- ☐ ABUSIVE RELATIONSHIP
- ☐ HALLUCINATIONS

- ☐ HOT FLASHES
- ☐ HEAT/COLD INTOLERANCE
- ☐ EXCESSIVE THIRST
- ☐ BLEEDING
- ☐ BRUISING
- ☐ NIGHT SWEATS
- ☐ SWOLLEN NODES

- ☐ HIVES
- ☐ ALLERGIES
- ☐ OTHER _____