

Patient Health History Form

PATIENT NAME: _____

DOB: _____ FACILITY: _____

1. PLEASE PROVIDE A COPY OF CURRENT MEDICATION LIST AND DOSAGES.

*If you do not have a copy, please contact the facility nurse to have a copy faxed to your Bluestone Vista provider:
507-385-4186*

2. CURRENT DIAGNOSIS:

3. MEDICATION ALLERGIES: *List specific reactions*

Contrast Dye, Reaction: _____

Latex, Reaction: _____

Other, please also specify reactions: _____

4. PREVIOUS SURGERIES OR RECENT HOSPITALIZATIONS: *Provide approximate dates*

5. IMMUNIZATIONS: *Provide last approximate date*

Pneumonia: _____ Flu: _____

Shingles: _____ Tetanus: _____

6. TOBACCO HISTORY:

Never smoked

Current smoker:

½ pack per day

1 pack per day

>1 pack per day

Number of Years Smoked _____

Former smoker:

½ pack per day

1 pack per day

>1 pack per day

Number of Years Smoked _____

Number of Years Quit _____

PATIENT NAME: _____

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7. LAST SPECIALTY EVALUATIONS: *Provide last approximate date and provider name*

Dental: _____ Provider: _____

Vision: _____ Provider: _____

Hearing: _____ Provider: _____

Last Colonoscopy/Sigmoidoscopy: _____ Provider: _____

Last Mammogram: _____ Provider: _____

Other Specialty Providers that follow you (Cardiologist, Urologist, etc.):

In the event of a specialty referral, I would like the Bluestone Referral Coordinator to contact my Medical POA (Long Form POA) prior to my appointment.

Name: _____ Relationship: _____ Phone: _____

8. **Hearing Aids:** Right Left Both

Dentures

Glasses

9. Advance Directive

Have completed a POLST

Would like more information

10. Marital Status

Married

Divorced

Separated

Single

Widowed

11. Family History – Please note family member next to diagnosis (i.e. Maternal Grandmother)

Diabetes, Family Member _____

Heart Disease, Family Member _____

Hypertension, Family Member _____

Cancer -Type: _____, Family Member: _____

Mental Health:

Depression, Family Member _____

Anxiety, Family Member _____

Bipolar, Family Member _____

Other: _____, Family Member: _____

12. Additional Information: _____

