MUENSTER
FAMILY
MEDICAL CLINIC

Amy Dangelmayr, FNP-C • Stephanie Rynor, FNP-C

PATIENT HEALTH HISTORY PG 1 of 2

Name_____ **Age:**_____ **Birthdate:**_____ **Gender:**_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed **Orientation:** ☐Heterosexual ☐Homosexual ☐Bisexual

Currently Living: ☐Alone ☐With Family ☐With Friends ☐With Significant Other

Profession (job):_____ ☐Working, Employed By:_____ ☐Retired

GENERAL
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Forgetful

EYE, EAR, NOSE, THROAT
- ☐ Visual Changes
- ☐ Double Vision
- ☐ Ringing in the ears
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Sinus Congestion or Pain
- ☐ Nosebleeds
- ☐ Hoarseness
- ☐ Difficulty Swallowing

DERMATOLOGICA
- ☐ Psoriasis
- ☐ Changes in moles
- ☐ Warts
- ☐ Rash

RESPIRATORY
- ☐ Wheezing
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Emphysema/COPD

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Moody
- ☐ Irritable
- ☐ Suicidal thoughts

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Murmur
- ☐ Rapid Heartbeat
- ☐ Heart Attack

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding

MUSCLE, JOINT, BONE
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Weakness
- ☐ Gout

NEUROLOGICAL
- ☐ Dizzy
- ☐ Loss of conciseness
- ☐ Siezures
- ☐ Numbness
- ☐ Frequent Headaches

ENDOCRINE
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Irregular Menses

QUESTIONS

Do you smoke?_____
_____Per Day
_____Per Week
_____Per Month

Do you smoke or use any form of THC? _____
If yes, what form? _____
How often?: _____

Do you vape? _____
If yes, how long?_____
How many cartridges per day? _____

Any other illicit drug use?
_____

Do you drink alcohol? ___
_____Per Day
_____Per Week
_____Per Month

Do you drink caffeine?___
_____Per Day
_____Per Week
_____Per Month

Do exercise?___
_____Per Day
_____Per Week
_____Per Month

Colonoscopy?___Y___N
Date:_____

Bone Density?___Y___N
Date:_____

MEN ONLY

Pain or lumps in testicles?
___Y___N

Penile (penis) itching, burning or discharge?
___Y___N

Prostate Disease or problems?___Y___N

Problems starting or stopping your urine stream?
___Y___N

Wake in the night to go to the bathroom?___Y___N

Sexual problems or concerns?___Y___N

WOMEN ONLY

Number of
_____ **pregnancies**
_____ **births**
_____ **miscarriages**
_____ **abortions**

Birth Control Method:
_____

Sexual problems or concerns?___Y___N

Vaginal itching, burning or discharge?___Y___N

Wake in the night to go to the bathroom?___Y___N

Mammogram?___Y___N
Date:_____

Date of last Pap Smear
_____

Hysterectomy?___Y___N
If yes, do you still have your ovaries? ___Y___N

Muenster Family Medical Clinic, LLC
PO Box 647
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940-759-2502

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PATIENT HEALTH HISTORY PG 2 of 2

CONDITIONS: Check all you have or have had in the past

☐ AIDS	☐ Cancer	☐ HIV Postitive	☐ Thyroid Problem
☐ Alcoholism	☐ Cataracts	☐ Kidney Disease	☐ Tuberculosis
☐ Anemia	☐ Chemical Dependency	☐ Liver Disease	☐ Ulcers
☐ Anorexia	☐ Diabetes	☐ Migraine Headaches	☐ Sleep Apnea
☐ Appendicitis	☐ Emphysema	☐ Mononucleosis	☐ Sexual Transmitted Disease
☐ Arthritis	☐ Epilepsy	☐ Multiple Sclerosis	Type:_____
☐ Asthma	☐ Glaucoma	☐ Pacemaker	☐ Other (please list)
☐ Bleeding Disorders	☐ Goiter	☐ Pneumonia	_____
☐ Breast Lump	☐ Heart Disease	☐ Psychiatric Care	_____
☐ Bulimia	☐ Hepatitis	☐ Stroke	_____

SURGERIES/HOSPITALIZATIONS: List all Surgeries

Surgery	Year	Reason	Physician

MEDICATIONS: List all medications you take (including over the counter herbs and medications taken)

Medication	Strength	How Often	Reason

ALLERGIES: List all allergies (medications, foods)

Allergy	Physician

FAMILY HISTORY: List diseases and age of death

Family Member	Disease(s)	Age of Death
Father		
Mother		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		

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PROTECTED HEALTH INFORMATION DISCLOSURE

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM MUENSTER FAMILY MEDICAL CLINIC, LLC MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, PLEASE FILL OUT THE LIST BELOW.

I give permission for my Protected Health Information to be disclosed for purposes of communication results, findings and care decisions to the family members and/or others listed below:

Name:_____ **Phone:**_____

Name:_____ **Phone:**_____

Patient/Representative may revoke or modify this specific authorization and that revocation or any modifications must be in writing.

_____ _____

Signature **Date**

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