Health Information Form

MARTHA STEWART CENTER for LIVING AT MOUNT SINAI

GENERAL INFORMATION

Name (Last) (First) (Middle)

Date of Birth

Social Security Number

Address (Street)

City	State	Zip Code	Country

Home Phone	Work Phone
Cell Phone	E-mail

Primary Insurance

Name

Policy Number

Address

Phone Number

Secondary Insurance

Name

Policy Number

Address

Phone Number

Other Health Care Providers

Name

Specialty

Phone Number

EMERGENCY CONTACTS

Primary Contact

Name (Last) (First) (Middle)

Relation to Patient

Home Phone	Work Phone
Cell Phone	Email

Preferred Method of Contact

Secondary Contact

Name (Last) (First) (Middle)

Relation to Patient

Home Phone	Work Phone
Cell Phone	Email

Advanced Directives

- ☐ HEALTH CARE PROXY
- ☐ LIVING WILL
- ☐ OTHER

Document Location (Physical Location)

Document Name

Address

City	State	Zip	Country

Legal Representative (Name of person who you have assigned legal authority)

Address

City	State	Zip	Country

Home Phone	Work Phone
Cell Phone	E-mail

Health Maintenance and Immunizations

	YES/NO	DATE	ANY ABNORMALITIES?
Bone Density (DEXA)			
Colonoscopy			
Eye Exam			
Mammogram			
Pap Smear			
Pneumonia Vaccine			
Podiatry (Foot Exam)			
Tetanus Vaccine			
Zoster Vaccine (Shingles)			
Flu Vaccine			
Dental Exam			

I. Do you exercise regularly? Type? Frequency?

II. Describe a typical day of eating.

Breakfast:

Lunch:

Dinner:

Snacks:

Medications

NAME	DOSE	FREQUENCY	REASON FOR MEDICATION
I.			
II.			
III.			
IV.			
V.			
VI.			
VII.			
VIII.			
IX.			
X.			

Allergies

*Please list allergy, and describe reaction.

MEDICINAL	ENVIRONMENTAL	FOOD
I.	I.	I.
II.	II.	II.

Active Medical Problems

MEDICAL PROBLEM	HOW LONG	DOCTOR
I.		
II.		
III.		
IV.		
V.		

Past History

*Medical issues not mentioned in active problems.

MEDICAL PROBLEM	HOW LONG	DOCTOR
I.		
II.		
III.		
IV.		
V.		

Surgery/Procedures

PROCEDURE	DATE	DOCTOR	HOSPITAL	DESCRIPTION
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

Description: _____

_____

VI. Previous Work Experience: _____

_____

VII. Birthplace: _____

VIII. Primary Language: _____

IX. Preferred Language of Communication: _____

_____

X. Children:

- ☐ Yes
- ☐ No

XI. Assistance Required for:

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

Family Members' Health

	MOTHER	FATHER	SIBLING(S)	CHILDREN
ENTER AGES OF RELATIVES				

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

Reason for Visit

[Check One]

☐ Establish Primary Care

☐ Consultation (Please specify referring provider and consult reason): _____

☐ Other (Please specify): _____

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
- ☐ VISION 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