



PATIENT HISTORY FORM

PRINT & COMPLETE: BRING THIS FORM WITH YOU TO YOUR APPOINTMENT

Name:

Age:

Date of Birth:

Who was your previous primary care provider? Dr.
What is the reason for requesting this visit?

PAST MEDICAL HISTORY: Please list any medical conditions from which you have suffered in the past or currently:

PAST HOSPITALIZATIONS - SURGERIES: Please list any surgeries, or hospitalizations, reason & date:

ALLERGIES: *List any allergic reactions or adverse side effects you've had to any drugs or other*

Drug/Food/Item	Type of Reaction

CURRENT MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION: *List all over-the-counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc.*

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS: *List all*

Herbal preparation	Dose	How often taken

FOR WOMEN ONLY:

Are you using any hormone based birth control?	
When was your last menstrual period?	
Number of Pregnancies:	
Number of Births:	



TELL US ABOUT YOURSELF:

Home situation Single Married (how long_____) Divorced (how long_____) Widowed (how long_____) Domestic partnership (how long_____)

Employment: Status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

Occupation: _____

Habits:

Do you smoke? No_____ Yes_____ If yes, how many packs per day? _____

Do you use alcohol? No_____ Yes_____ If you have quit, how long ago? _____

If yes, how often do you drink? _____

If you have quit, how long ago? _____

Do family or friends worry about your alcohol intake? Y / N

Do you exercise regularly? No_____ Yes_____

How often? _____/week What activity? _____ Minutes per session _____

Number of times you eat "fast food" per week? _____

Do you/have you used illicit drugs? No Yes

Do you have smoke detectors? No Yes

Do you wear a helmet when riding a bike or motorcycle? No Yes

Do you use seatbelts? No Yes

Transfusions: Have you ever received a blood transfusion? No_____ Yes_____ When? _____

Immunizations: if YES, give approximate year given

Pneumococcal No_____ Yes_____

H. influenza No_____ Yes_____

Hepatitis B (series of 3) No_____ Yes_____

Tetanus booster No_____ Yes_____

FAMILY HISTORY: (Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives)

	Maternal Grandparent	Paternal Grandparent	Father	Mother	Brother	Sister	Son	Dtr	Other
Colon or rectal cancer									
Breast or other cancer									
Stroke/Heart Attack before age 65									
Diabetes									
High blood pressure									
High cholesterol									
Alzheimer's Disease									
Alcohol/drug abuse									
Depression									
Bipolar Disorder									
Genetic disorder									
Other (Prostate ca, Ovarian Ca, Melanoma, Bleeding problems, Blood clots)									

Age of Parents: _____ **Mother** Alive Deceased _____ **Father** Alive Deceased

Number & Age of Children: _____ **Healthy:** Yes No

Are you experiencing an unusually stressful situation? Explain _____

Are there any specific personal issues you would like to bring up at the time of your visit?

Explain: _____



Patient History Form

SYMPTOM REVIEW

General

- change in weight: _____ lbs during last 6 months
- poor sleep
- fevers
- feeling depressed
- feeling forgetful
- night sweats or chills

Head, Eyes, ears, nose, throat

- headaches or migraines
- light headedness or dizziness
- bleeding gums
- blurred vision
- other change in vision
- dry eyes
- history of glaucoma or cataracts
- loss of hearing
- ringing in ears
- sinus problems
- hoarseness or voice changes
- dentures: type _____

Cardiovascular

- chest pain
- palpitations or rapid heart beat
- history of angina or heart attack
- history of high blood pressure
- history of irregular beat or murmur
- history of poor circulation
- Date/Result of last EKG _____
- Result of any other cardiac tests _____

Pulmonary/lungs

- shortness of breath
- difficulty breathing
- difficulty breathing lying down
- persistent cough
- sputum
- coughing up blood
- history of asthma or wheezing

Gastrointestinal

- poor appetite
- abdominal pain or cramps
- bloating after meals
- indigestion
- difficulty swallowing
- diarrhea
- constipation
- recent change in bowel habits
- nausea or vomiting
- vomiting blood
- rectal bleeding or blood in stools
- history of jaundice, liver disease or abnormal liver tests
- history of hemorrhoids
- history of colitis
- history of Hepatitis
- Date & result of last colonoscopy _____

Genitourinary

- frequent urination
- inability to hold urine
- hesitancy during urination
- burning or painful urination
- blood in urine
- urinating at night
- Hx of recurrent urinary tract infections
- Hx of kidney stones
- Hx of STDs (eg: Syphilis, Gonorrhea, Herpes, HIV)

Muscle/joint/bone

- swelling of ankles or legs
- muscle aches, pains, or weakness
- joint aches pains or swelling
- Hx of chronic fatigue or tiredness
- Hx of osteoporosis
- Have you ever fallen in last 2 years

Neurologic/Psychiatric

- history of stroke
- blackouts or loss of consciousness
- numbness or tingling in fingers OR hands, OR feet
- leg cramps when walking
- leg cramps or movement at night
- Hx of seizures
- Do you ever feel depressed or anxious or out of control
- History of suicide attempt

Skin

- Itching: where _____
- easy bruising
- new or change in moles
- eczema
- rashes
- lumps or bumps

Endocrine

- history of diabetes
- history of thyroid disease
- change in tolerance to hot or cold weather
- excessive thirst
- excessive urination

Women only

- History of abnormal Pap smear
- History of bleeding between periods
- vaginal discharge
- breast discharge or lumps
- date of last mammogram _____
- date of last pap smear _____

Men only

- penile discharge
- impotence
- date of last PSA
- date of last prostate exam

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE (3 pages) TO YOUR APPOINTMENT