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PATIENT HISTORY FORM

Patient Name: ______________________________________ Date of Birth:______________________________

HOME SITUATION: (circle, or add in writing):

Single_____ Married (how long_____) Divorced (how long_____) Widowed (how long_____) Domestic partnership_____

How many children? ______ How many biological children? _________ Are they healthy? ___________

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

Occupation/type of work/jobs: ____

HABITS: (circle if applicable):

Smoke/ Smokeless tobacco	Alcohol	Recreational Drugs	Exercise
# packs/day: Quit?	# drinks/week: Quit?	Type: Quit?	How often? Type?

PAST MEDICAL HISTORY:
Please list other diseases from which you currently suffer (heart, lung, etc.):
-
-
-
-
-
-
-
-

Please list other medical conditions from which you have suffered in the past
-
-
-
-

Please list any surgeries (operations), and/or hospitalizations:
-
-
-
-

IMMUNIZATIONS; If YES, give approximate year given
Pneumococcal No_________ Yes__________
Hepatitis A No_________ Yes__________
Hepatitis B No_________ Yes__________
Tetanus No_________ Yes__________
Shingles No_________ Yes__________

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction:

CURRENT MEDICATIONS (including over the counter medications and herbal supplements):

Medications	Dose	How often taken

Patient Name:_________________________

FAMILY HISTORY:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives, please mark those who are deceased with a capital D:

Illness/Condition	Father	Mother	P.Grandfather	P.Grandmother	M.Grandfather	M.Grandmother
Colon or rectal cancer						
Breast /Prostate cancer						
Ovarian cancer						
Heart disease						
Diabetes						
High blood pressure						
Liver disease						
High cholesterol						
Alcohol/drug abuse						
Depression/psychiatric illness						
Genetic (inherited) disorder						
Thyroid disease						
Melanoma						
Other						

SYMPTOM REVIEW

Gastrointestinal

- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular

- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular heartbeat
- ☐ history of poor circulation

Pulmonary/lungs

- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone

- ☐ swelling of ankles or legs

pain, weakness or numbness in

- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic

- ☐ history of stroke
- ☐ blackouts or loss of consciousness
- ☐ numbness or tingling in limbs
- ☐ migraine headaches

General

- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat

- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary

- ☐ frequent or painful urination
- ☐ blood in urine

Skin

- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine

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

Women only

- ☐ abnormal Pap smear
- ☐ bleeding between periods

date of last mammogram_________________________

date of last pap smear___________________________

date of last menses ______________________________

ANYTHING ELSE?

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