

PATIENT HISTORY FORM

Name _____ Occupation _____

At which number can we leave confidential messages? (Please circle) Home Work Cell Any

Do you have a Significant Other? Yes No Marital Status: _____

Children? Yes No _____

Medical History – Please Circle if you have ever had:

Allergies/Sinus Trouble	Congestive Heart Failure	Kidney Disease
Anemia	Diabetes (circle complications)	Liver Disease
Asthma / Emphysema	With: eye, kidney, nerve damage	Lupus, Sarcoidosis
Anxiety/Depression/Bipolar	Fibromyalgia	Neuropathy
Joint pain in the _____	Heart Attack or Blockages	Stomach Ulcers/ Acid Reflux
Abnormal Heart Rhythm	High Blood Pressure	Stroke
Back Pain	High Cholesterol	Other _____
Cancer _____	HIV	Other _____

Past Surgical History – Please Circle

Appendix removed	Hysterectomy – Partial/Total
Gallbladder removed	Reason? _____
Heart bypass / Stent	Mastectomy
Back surgery	Amputation
Other _____	_____

Specialists (if any) you are currently seeing: _____

Medication: Dose Number of times per day

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Medication Allergies – List what happens: _____

Other Allergies – List what happens: _____

Family History:	<u>Condition</u>	<u>Who had it?</u>	<u>Condition</u>	<u>Who had it?</u>
	Heart Attack _____		Uterine Cancer _____	
	Congestive Heart Failure _____		Ovarian Cancer _____	
	Diabetes _____		Prostate Cancer _____	
	Dialysis for Kidney Disease _____		Colon Cancer _____	
	Breast Cancer _____		Other _____	

Menstrual History: **Do you have regular monthly periods?** Yes No
 _____ Days Long. **Heavy?** Yes No **Painful?** Yes No
What age did you start having periods? _____
When did you stop having periods? _____

Have you ever used tobacco? Yes No. **Quit?** Yes No. **How many years?** _____ **Packs a day** _____

Do you drink any alcohol? Yes No. **What do you drink?** _____ **How much?** _____

Have you ever done drugs? Yes No. **What kind?** _____

Preventative Care:	<u>When was this test last done?</u>	<u>Results</u>	<u>Doctor</u>
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Prostate Blood Test	_____	_____	_____
Stool Cards	_____	_____	_____
Colonoscopy	_____	_____	_____
Pneumonia Vaccine	_____	_____	_____
Tetanus Vaccine	_____	_____	_____
Bone Density / DXA	_____	_____	_____
Other	_____	_____	_____

REASON FOR TODAY'S VISIT – Top 2 Problems:

Do you need (please circle):

Disability paperwork	Surgical clearance
Return to work or school note	Prescription refills
Bedside Commode	Rolling Walker
Cane	Other _____

Are you interested in (please circle):

Weight Loss?	HIV screening?	Diabetes Screening?	Preventing Pregnancy?
Screening for Sexually Transmitted Diseases?	"Shingles" Vaccine	The Cervical Cancer Vaccine	