PATIENT HISTORY FORM

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PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT

Your Name: _____ Date of Birth: _____ Todays Date: _____

TELL US ABOUT YOURSELF:

Home situation (check or place number for):

Single (how long _____) Married (how long_____) Divorced (how long_____) Widowed (how long_____)

Domestic partnership (how long_____) Number of Children?_____ Are they healthy? Y N

Employment:

Status: full-time part-time retired disabled homemaker

Occupation/type of work/jobs:_____

Habits: Do you smoke? No Yes If yes, how many packs per day?_____

If you have quit, how long ago?_____

Do you use alcohol? No Yes If yes, how often do you drink? 1 a week

If you have quit, how long ago?_____

Do family or friends worry about your alcohol intake? No

Any Toxic Exposure? No Yes Do you wear seatbelts? Yes No

Have you ever had problems with drug use?_____

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), reason for the surgery, and date of surgery:

_____

_____

MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, inhalers, etc.)

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS (Include Caffeine, foodstuffs, etc.)

Preparation	Dose	How often taken

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

_____

_____

FAMILY HISTORY:
Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives. If not living place age at death.

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
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 beat
- ☐ 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

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

Anything else?
- ☐ Are you experiencing an unusually stressful situation?
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit?

Immunizations: (If YES, give approximate year given.)

Pneumococcal No ☐ Yes_____
Hepatitis A No ☐ Yes_____
Hepatitis B No ☐ Yes_____
Tetanus No ☐ Yes_____

Transfusions: Had a blood transfusion? No ☐ Yes ☐

Date of Last colonoscopy: _____
Women: Date last Mamo: _____, Pelvic Exam: _____
Men: Date last PSA: _____, Rectal Exam: _____

PLEASE BE SURE TO SIGN AND DATE. BRING THIS COMPLETED QUESTIONAIRE TO YOUR APPOINTMENT!

Name: _____ **Date:** _____