PATIENT HISTORY

DATE: _______________

Name (Last)	(First)	(Middle)	Occupation
Birth date (mo/day/yr)	Age	Sex M/F	Marital Status S/M/W/D

DRUG ALLERGY/REACTION	**FOOD ALLERGY/REACTION**

MEDICATIONS TAKEN AT HOME INCLUDING OVER THE COUNTER

Medication	Dose	Frequency	Medication	Dose	Frequency
1) Medication *Medication Example*	Dose *20 ml*	Frequency *2 times a day*	7) Medication	Dose	Frequency
2) Medication	Dose	Frequency	8) Medication	Dose	Frequency
3) Medication	Dose	Frequency	9) Medication	Dose	Frequency
4) Medication	Dose	Frequency	10) Medication	Dose	Frequency
5) Medication	Dose	Frequency	11) Medication	Dose	Frequency
6) Medication	Dose	Frequency	12) Medication	Dose	Frequency

FAMILY HISTORY Have any of your parents, grandparents, brother, sisters or children ever had?

	Yes	No		Yes	No		Yes	No
Heart attack			Bleeding problem or anemia			Cancer		
High blood pressure			Coronary artery disease			**Family History Comments**		
Diabetes			Mental illness					
Depression			Kidney disease					

PERSONAL MEDICAL HISTORY

Cardiovascular History	Yes	No
Peripheral vascular disease		
High blood pressure		
High cholesterol		
Deep vein thormbosis		
Heart disease		
Chest pain/angina		
Angioplasty		
Heart surgery		
Cardiovascular History Comments		

Gastrointestinal History	Yes	No
Peptic ulcers		
Bowel disease		
Irritable bowel syndrome		
Liver disease		
Gastroesophgeal reflux disease (GERD)/Reflux		
Gall bladder trouble		
Gastrointestinal History Comments		

Neurological History	Yes	No
Migraines		
Seizures		
Transient ischemic attack (TIA)		
Depression		
Chronic fatigue		
Dementia		
Neurological History Comments		

Musculoskeletal History	Yes	No
Arthritis		
Back trouble		
Chronic pain		
Fractures		
Osteoporosis		
Musculoskeletal History Comments		

Respiratory History	Yes	No
Shortness of breath		
Asthma		
Cough		
Bronchitis		
Hay fever		
Pneumonia		
Congestive Heart Failure (CHF)		
Chronic Obstructive Pulmonary Disease (COPD)		
Respiratory History Comments		

Kidney History	Yes	No
Kidney failure		
Bladder control problems		
Trouble urinating		
Prostate problems		
Past urinary track infection (UTI)		
Kidney History Comments		

Endocrine History	Yes	No
Diabetes		
Thyroid disease		
Gout		
Hypoglycemia		
Endocrine History Comments		

HEENT History	Yes	No
Recurrent ear infection		
Recurrent sinusitis		
Vertigo		
Cataracts		
Glaucoma		
HEENT History Comments		

Integumentary History	Yes	No
Rashes		
Eczema		
Acne		
Integumentary History Comments		

PATIENT HISTORY (continued) NAME ______________________________

Psychiatric History	Yes	No
Anxiety		
Persistent depression		
Panic attacks		
ADHD		
Psychiatric History Comments		

For Men Only	Yes	No
Prostate Cancer		
Previous PSA		
Sexually active		
Sexually transmitted diseases		
Male History Comments		

Infectious Disease History	Yes	No
Hepatitis		
AIDS		
MRSA		
HIV		
Chicken pox		
Infectious Disease History Comments		

For Women Only	Yes	No
Breast cancer		
Cervical cancer		
Ovarian cancer		
Uterine cancer		
Sexually active		
Sexually transmitted diseases		
Number of pregnancies		
Age at menopause		
Women History Comments		

SURGICAL HISTORY (Indicate if you have had any of the following surgical procedures)

Head/Ears/Eyes/Nose/Thrat

- ☐ Cataract extraction (year_____)
- ☐ Tonsillectomy (year_____)
- ☐ Other head surgery (year_____)
- ☐ Other eye surgery (year_____)
- ☐ Other ear surgery (year_____)
- ☐ Other nasal surgery (year_____)
- ☐ Other throat surgery (year_____)

Endocrine

- ☐ Thyroid surgery (year_____)
- ☐ Other endocrine surgery(yr_____)

Respiratory

- ☐ Bronchoscopy (year_____)
- ☐ Other chest surgery (year_____)

Cardiovascular

- ☐ Coronary artery bypass gr. (yr__)
- ☐ Coronary stent (year_____)
- ☐ Heart transplant (year_____)
- ☐ Pacemaker (year_____)
- ☐ Valve replacement (year_____)
- ☐ Other cardiac surgery (year_____)

Gastrointestinal

- ☐ Appendectomy (year_____)
- ☐ Cholecystectomy (year_____)
- ☐ Colectomy (year_____)
- ☐ Gastric bypass (year_____)
- ☐ Other GI surgery (year_____)

Genitourinary

- ☐ Bladder surgery (year_____)
- ☐ Kidney stone extraction (yr_____)
- ☐ Other GU surgery (year_____)

Genitourinary - male

- ☐ Prostatectomy (year_____)
- ☐ Vasectomy (year_____)

Gynecologic

- ☐ C-Section (year_____)
- ☐ Hysterectomy (year_____)
- ☐ Tubal ligation (year_____)
- ☐ Other GYN surgery (year_____)

Musculoskeletal

- ☐ Joint replacement (year_____)
- ☐ Other musculoskeletal srg (yr___)

Integumentary/Skin

- ☐ Skin cancer removal (year_____)
- ☐ Other integumentary surg. (yr___)

Neurologic

- ☐ Spinal surgery (year_____)
- ☐ Other neurologic surgery (yr___)

Breast

- ☐ Breast biopsy (year_____)
- ☐ Lumpectomy (year_____)
- ☐ Mastectomy (year_____)
- ☐ Other breast surgery (year_____)

SOCIAL HISTORY

Occupation

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Family Household

Family Member Name	Age	Relationship

DIET HABITS	Yes	No
Well balanced diet		
Weight gain		
Weight loss		

PREVIOUS IMMUNIZATION OR DIE DISEASE

			Date (Last Immun.)
Tetanus			
German Measles (Rubella)			
Measles (Rubeola			
Polio			
Influenza			
Hepatitis			
Chicken Pox			

SAFETY HABITS	Yes	No
Seat belt use		
Physical abuse by someone close to you in past year		
Emotional abuse by someone close to you in past year		
HEALTHY HABITS AND SELF CARE		
Feelings of overwhelming sadness		
Uncontrollable anger		
ALCOHOL		
Alcohol intake		
SUBSTANCE USE		
Drug use		
Frequency		
TOBACCO		
Tobacco status		
Cigarette use		
Other tobacco		
Age/year started		
Age/year quit		
EXERCISE		
Physical activity		
Frequency: Duration:		

Patient Signature Date