PATIENT HISTORY FORM

NAME	DATE OF BIRTH	TODAY'S DATE

OCCUPATION	MARITAL STATUS
	❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated

HOME PHONE	WORK PHONE	CELL/ALTERNATE PHONE

FAMILY:

Please list the age and state of health of your immediate relatives (spouse, mother, father, sisters, brothers, children). Consider the following diseases and list beside which relatives (if any) have the stated disease. Please feel free to add any significant illnesses not listed. If deceased, please list cause of death.

Alcoholism	Arthritis	Cancer	Gout	Kidney disease	Mental Illness	Seizures
Allergies/Hay Fever	Birth defects	Diabetes	Heart disease	Liver disease	Migraines	Stroke
Anemia	Bleeds easily	Glaucoma	Hypertension	Lung disease	Osteoporosis	Thyroid disease

Spouse:	Brothers:
Mother:	
Father:	Sisters:
Children:	

MEDICATIONS:

List all medications that you are now taking. **Please include vitamins and herbs.**

1.	**dosage:**	**frequency:**	**8.**	**dosage:**	**frequency:**
2.	**dosage:**	**frequency:**	**9.**	**dosage:**	**frequency:**
3.	**dosage:**	**frequency:**	**10.**	**dosage:**	**frequency:**
4.	**dosage:**	**frequency:**	**11.**	**dosage:**	**frequency:**
5.	**dosage:**	**frequency:**	**12.**	**dosage:**	**frequency:**
6.	**dosage:**	**frequency:**	**13.**	**dosage:**	**frequency:**
7.	**dosage:**	**frequency:**	**14.**	**dosage:**	**frequency:**

PAST MEDICAL HISTORY:

Please check (✔) any conditions you have or have had in the past

EYES
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular degeneration
- ❑ Post eye surgery

ENTM
- ❑ Allergy testing or shots
- ❑ Persistent change in voice
- ❑ Polyps
- ❑ Swallowing problems
- ❑ Tonsillitis

CARDIOVASCULAR
- ❑ Anemia
- ❑ Bleeding problems
- ❑ Chest pain
- ❑ Heart disease
- ❑ Heart murmur
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Pacemaker
- ❑ Past cardiac cath
- ❑ Past stress test
- ❑ Rheumatic Fever
- ❑ Stroke

RESPIRATORY
- ❑ Asthma
- ❑ Black Lung
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Tuberculosis exposure

GASTROINTESTINAL
- ❑ Blood in stool
- ❑ Colon polyps
- ❑ Gall stones
- ❑ Hepatitis
- ❑ Hiatal hernia
- ❑ Liver disease
- ❑ Treatment for heart burn

GENITOURINARY
- ❑ Enlarged prostate
- ❑ Frequent nighttime urination
- ❑ Gonorrhea
- ❑ Herpes
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Sexual disfunction
- ❑ Sexually trans disease

GYNECOLOGIC
- ❑ Abnormal pap
- ❑ Breast lump
- ❑ Irregular periods
- ❑ Miscarriages
- ❑ Urethral disf/inf
- ❑ Vaginal infections

MUSCULOSKELETAL
- ❑ Arthritis
- ❑ Carpal Tunnel Syndrome
- ❑ Gout
- ❑ Joint injections
- ❑ Joint surgery
- ❑ Polio

NEUROLOGICAL
- ❑ Fainting spells
- ❑ Frequent falls
- ❑ Headaches
- ❑ Head injury
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Seizures

PSYCHOLOGICAL
- ❑ Anorexia
- ❑ Bulimia
- ❑ Chemical dependency
- ❑ Psychiatric care

ENDOCRINE
- ❑ Diabetes
- ❑ Goiter
- ❑ Thyroid problems

IMMUNOLOGIC
- ❑ AIDS
- ❑ HIV Positive

OTHER
- ❑ Blood Clots
- ❑ Sleeping problems
- ❑ Cancer
- ❑ History of Physical Abuse
- ❑ History of Sexual Abuse
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

DRUG ALLERGIES OR ALLERGIC REACTION TO MEDICATION OR SUBSTANCE: *i.e.*, Penicillin, X-ray dyes, etc.

NAME	DATE OF BIRTH

SURGERIES / HOSPITALIZATIONS			SERIOUS ILLNESS / INJURY		
YEAR	HOSPITAL	REASON FOR SURGERY / HOSPITALIZATION		DATE	OUTCOME

Have you ever had a blood transfusion? ❑ No ❑ Yes If yes, give approximate date(s): _____

GYNECOLOGIC AND OBSTETRIC HISTORY

Age at onset of period: _____ Frequency: _____ Duration: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Have you had any of the following?

Prolonged or abnormal bleeding: ❑ No ❑ Yes _____

Leakage of urine: ❑ No ❑ Yes _____

Pelvic Pain: ❑ No ❑ Yes _____

Abnormal Discharge: ❑ No ❑ Yes _____

History of Abnormal PAP smear: ❑ No ❑ Yes _____

Date of last PAP smear: _____

Date of last mammogram: _____

Age of onset of menopause: _____

Are you taking hormone replacement therapy? _____

OCCUPATIONAL CONCERNS

Check (✔) if your work exposes you to the following:

❑ Stress
❑ Hazardous Substances
❑ Heavy Lifting
❑ Other: _____

IMMUNIZATIONS

Check (✔) diseases which you have had in the past or have been immunized against and approximate date:

❑ Pneumovax _____ ❑ Chicken Pox _____
❑ Polio _____ ❑ Tetanus _____
❑ Influenza _____ ❑ Measles/Mumps/Rubella _____
❑ Small Pox _____ ❑ Typhoid _____
❑ Hepatitis B _____ ❑ Hepatitis A _____
❑ PPD (skin test for tuberculosis) _____
❑ Other: _____

HEALTH HABITS

Check (✔) which items you use and describe how much you use and/or how often habit is engaged in. **(how much)** **(how often)**

❑ Caffeine _____ _____
❑ Drugs _____ _____
❑ Tobacco Use _____ _____
❑ 2nd Hand Smoke Exposure _____ _____
❑ Alcohol _____ _____
❑ Seatbelts _____ _____
❑ Special Diet _____ _____
❑ Self Breast Exam _____ _____
❑ Self Testicular Exam _____ _____

Please indicate the date of your last:

Stool hemoccult: _____ PSA test: _____

Colonoscopy: _____

Do you feel safe at home? ❑ No ❑ Yes

Are you sexually active? ❑ No ❑ Yes

Are you using birth control? ❑ No ❑ Yes

If yes, what type? _____

Do you own a gun? ❑ No ❑ Yes

If Yes, is it locked and unavailable to children? ❑ No ❑ Yes

Do you have a living will? ❑ No ❑ Yes

Do you have a donor card? ❑ No ❑ Yes

Do you have an advance directive? ❑ No ❑ Yes

Do you drive a car? ❑ No ❑ Yes

OTHER PHYSICIANS: Please list other physicians that you are seeing regularly

Patient Signature	Date
Reviewed By	**Date**