



Patient History Form

DATE: _____

Patient Name: _____ Age: _____ Date Of Birth: _____

The following information is very important to your health. Please take time to fully and completely fill out these forms. Important decisions are based on this information.

Height: _____ Weight: _____

ALLERGIES: Are you allergic to any medications (including over-the-counter drugs or iodine, tape or latex)?
Circle one: Yes No If yes, please complete the following:

Drug Allergy:	Reaction:	Other Allergy:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL PROBLEMS: Please list all medical problems you have.

MEDICATIONS: Please list all medications (specify dosage and frequency) you are currently taking, including aspirin, over-the-counter medications, vitamins and herbal supplements.

Please list your PAST medications.

OPERATIONS: Please list all operations you have had.

Operation:	Date:	Operation:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY:
 Do you use any type of tobacco product? Yes No If yes, how much per day _____
 Have you EVER used any type of tobacco product? Yes No Date Quit _____
 Do you drink alcohol? Yes No If yes, how often? _____
 Do you use illicit drugs? Yes No If yes, please list: _____
 For women: Last menstrual period: _____ Number of Pregnancies: _____ Number of Live Births: _____

Physician Signature: _____ **Date:** _____



Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY: Have you been diagnosed with and/or are you currently having any of the following symptoms?
Please check all that apply.

Neurologic/HEENT:

Have you had any neurological problems? Yes ___ No ___

- ___ Numbness/tingling
- ___ Loss of strength
- ___ Stroke (CVA/TIA)
- ___ Headaches-type _____
- ___ Seizures/epilepsy
- ___ Multiple Sclerosis
- ___ Ear problems
- ___ Eye problems
- ___ Nose/sinus problems
- ___ Throat problems

Musculoskeletal/Skin:

Have you had any muscle/bone problems? Yes ___ No ___

- ___ Back or neck problems/Joint pain
- ___ Loss of sensation
- ___ Rash/skin breakdown
- ___ Arthritis-type _____
- ___ Fractures-type _____
- ___ Osteoporosis

Endocrine:

Have you had any endocrine problems? Yes ___ No ___

- ___ Tired/Sluggish
- ___ Excessive thirst
- ___ Diabetes
- ___ Thyroid problems

Respiratory:

Have you had any breathing problems? Yes ___ No ___

- ___ Wheezing
- ___ Shortness of breath
- ___ Productive or bloody cough
- ___ Asthma
- ___ Emphysema/COPD
- ___ Bronchitis
- ___ Pneumonia
- ___ Sleep apnea
- ___ Pulmonary embolism

Cardiac:

Have you had any heart problems? Yes ___ No ___

- ___ Chest pain (Angina)
- ___ Palpitations/heart racing
- ___ Congestive heart failure
- ___ Heart attack
- ___ High blood pressure
- ___ Pacemaker
- ___ Heart valve
- ___ Rheumatic fever

Blood/Immune System:

Have you had any problems? Yes ___ No ___

- ___ Swollen glands
- ___ Anemia
- ___ Cirrhosis
- ___ DVT/phlebitis/blood clots
- ___ Jaundice
- ___ Lupus
- ___ Bleeding disorders
- ___ Scleroderma

Digestive (Stomach/Bowel):

Have you had any digestive problems Yes ___ No ___

- ___ Abdominal pain
- ___ Nausea/vomiting
- ___ Constipation
- ___ Diarrhea
- ___ Colitis
- ___ Diverticulitis
- ___ Hiatal hernia/reflux disease
- ___ Irritable bowel syndrome
- ___ Ulcers
- ___ Pancreatitis
- ___ Rectal Bleeding/rectal pain
- ___ Change in bowel habits
- ___ Hemorrhoids

Genitourinary/GYN:

Have you had any problems? Yes ___ No ___

- ___ Kidney problems/stones
- ___ Bladder infections
- ___ Kidney failure
- ___ Hernia

Men:

- ___ Prostate problems
- ___ Loss of sexual function

Women:

- ___ Uterine problems
- ___ Ovarian problems
- ___ Infertility
- ___ Bleeding between periods
- ___ Ever taken birth control pills? When: _____
- ___ Complications from childbirth

Constitutional:

Have you had any problems? Yes ___ No ___

- ___ Fever
- ___ Chills
- ___ Weight Loss
- ___ Night sweats

Communicable Diseases:

Have you had any problems? Yes ___ No ___

- ___ AIDS/HIV
- ___ Hepatitis A/B/C
- ___ Sexually transmitted disease
- ___ Tuberculosis

Psychological (Emotional):

Have you had any problems? Yes ___ No ___

- ___ Nervousness
- ___ Anxiety
- ___ Depression
- ___ Other _____

Physician Signature: _____

Date: _____



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Cancer:

Have you ever been diagnosed with cancer? Yes ___ No ___

Type of Cancer:	Treatment:

Other:

Have you had any other medical problems not listed here?

Yes ___ No ___ Please list below:

FAMILY HISTORY:

Please check which, if any, of your blood relatives had any of the following conditions:

Condition	Parent	Siblings/ Children	Other Relatives (Grandparents, Aunts, Uncles, Cousins, etc.)	No Family History	Don't Know
Diabetes					
Heart Disease					
Hypertension					
Gallstones					
Obesity					
Sleep Apnea					
Asthma					
Blood clots					
Cancer					
Stroke					
Kidney Disease					
Bleeding Problems					
Gout					
Allergies					
Dermatitis/Eczema					
High Cholesterol					
Osteoporosis					
Autoimmune Disease					
Psychiatric Illness					

Physician Signature: _____

Date: _____

*****No changes to history*****

Physician Signature: _____

Date: _____