Patient History

PLEASE PRINT This information becomes part of your confidential medical record

Name:____________________________________ **Date of Birth:**__________________

Primary Care Provider:______________________________ **Referring Provider:**____________________

Presenting Problem: Please describe the specific problems or questions you would like to have addressed

Medications (include supplements and over the counter drugs)

Name	Dose	Frequency	Purpose

Pharmacy/ Local: Mail Order:

Allergies

Agent	Reaction

Past Surgical History

Type of surgery	Date	Surgeon/City	Reason

Family History

Relationship	Age	Medical Conditions / Cause of death
Mother	❑ deceased	
Father	❑ deceased	
Brother(s) #____	❑ deceased	
Sisters(s) #____	❑ deceased	
Children #____	❑ deceased	

Social History / Habits

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated

Children: ❑ No ❑ Yes; if yes, how many children:_____________

Sexually Active: ❑ Yes ❑ No

Occupation:____

Smoking/Tobacco: ❑ Never ❑ Yes, year started:____________ ❑ Quit; year quit:_____________

cigarettes:	❑ Yes	❑ No	pks/day:	
cigars:	❑ Yes	❑ No	cigars/day:	
smokeless:	❑ Yes	❑ No	cans/day:	
Alcohol:	❑ Yes	❑ No	drinks/day:	
Marijuana:	❑ Yes	❑ No	amt:	
Street drugs:	❑ Yes	❑ No	type:	
Caffeine:	❑ Yes	❑ No	type:	cups/day:
Exercise:	❑ Yes	❑ No	type:	amount:

Name:____ Date of Birth:________________________

Medical History (Please mark any conditions you've been diagnosed with in the past)

- ❑ Glaucoma
- ❑ Cataracts
- ❑ Macular degeneration
- ❑ Hearing loss
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Angina
- ❑ HIV/AIDS
- ❑ Diverticulitis
- ❑ Hepatitis
- ❑ Reflux / GERD / Ulcers
- ❑ Hiatal hernia
- ❑ Kidney stones
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Stroke
- ❑ Seizure / Epilepsy
- ❑ Anemia
- ❑ Blood clots
- ❑ Arthritis
- ❑ Psoriasis
- ❑ Eczema
- ❑ Depression
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Atrial Fibrillation/Arrhythmia
- ❑ Heart Attack
- ❑ Coronary Artery Disease
- ❑ Congestive heart failure
- ❑ Pacemaker
- ❑ Asthma
- ❑ COPD / Emphysema
- ❑ Tuberculosis
- ❑ Pulmonary embolus

Cancer: Type:____

Other:

For children less than 5 years old: Birth Weight__________ ❑ **Complications** ❑ **Breech**

Review of Systems (Please complete the following by checking Yes or No)

General	YES	NO
Fever		
Chills		
Weight loss		
Malaise/Fatigue		
Sweating		
Weakness		

Skin	YES	NO
Rash		
Itching		

HENT	YES	NO
Headaches		
Hearing loss		
Ringing in ears		
Ear Pain		
Ear discharge		
Nosebleeds		
Congestion		
Upper airway wheezing		
Sore throat		

Eyes	YES	NO
Blurred vision		
Double vision		
Light sensitivity		
Eye pain		
Eye discharge		
Eye redness		

Cardiovascular	YES	NO
Chest pain		
Palpitations		
Shortness of breath laying down		
Pain in limbs		
Leg swelling		
Shortness of breath at night		

Respiratory	YES	NO
Cough		
Coughing up blood		
Sputum production		
Shortness of breath		
Wheezing		

Gastrointestinal	YES	NO
Heartburn		
Nausea		
Vomiting		
Abdominal pain		
Diarrhea		
Constipation		
Blood in stool		
Black stools		

Genitourinary	YES	NO
Painful urination		
Urgency		
Frequency		
Blood in urine		
Flank pain		

Musculoskeletal	YES	NO
Muscle pain		
Neck pain		
Back pain		
Joint pain		
Falls		

Endo/Heme/Aller	YES	NO
Easy bruise/bleed		
Environmental allergies		
Excessive thirst		

Neurological	YES	NO
Dizziness		
Tingling		
Tremor		
Loss of feeling		
Speech change		
Focal weakness		
Seizures		
Loss of consciousness		

Psychiatric	YES	NO
Depression		
Suicidal ideas		
Substance abuse		
Hallucinations		
Nervous/Anxious		
Insomnia		
Memory loss		

Other:

Contraception: ❑ Yes ❑ No Type:____________ Vaginal Deliveries: #____________ C-Section: #____________

Last Menstrual Period: ____________________ Miscarriages / Abortions #____________