PATIENT HISTORY

NAME: _____ DATE TODAY: _____

DATE OF BIRTH: _____ REFERRED BY/PREVIOUS PCP: _____

RELATIVE	**AGE**	**CURRENT HEALTH**	**(AGE WHEN DECEASED)**
FATHER			
MOTHER			
SISTER(S)			
BROTHER(S)			
CHILDREN			

SPOUSE'S NAME _____ AGE _____ HEALTH _____

OTHER RELATIVES SEEN HERE _____

HAS ANY BLOOD RELATIVE EVER HAD THE FOLLOWING?	**WHO? ↓**
ARTHRITIS	
ASTHMA	
CANCER (WHAT KIND)	
MELANOMA	
DIABETES	
HEART ATTACK	
HYPERTENSION	
STROKE	
ALTZHEIMER'S	
TB	
OSTEOPOROSIS	
THYROID	
ANY INHERITED DISEASE	

HAVE YOU EVER USED TOBACCO? **YES NO** DO YOU NOW? **YES NO**

HOW MANY PACKS PER DAY DO/DID YOU SMOKE? _____

HOW MANY TOTAL YEARS? _____ WHEN DID YOU STOP? _____

HOW MANY PACKS PER DAY HAVE YOU AVERAGED OVER THAT TOTAL TIME? _____

ALCOHOL USE: ☐ **NONE** ☐ **1-2 DRINKS/DAY** ☐ **2+/DAY** ☐ **1X/WEEK** ☐ **2X/WEEK** ☐ **SOCIALLY** ☐ **RARELY**

WHAT DO YOU DO FOR EXERCISE? _____

FREQUENCY PER WEEK? _____ DURATION PER SESSION? _____

HOW MUCH COFFEE, TEA OR CAFFEINATED SODA PER DAY? _____

DO YOU CONSIDER YOUR DIET: ☐ **LOW FAT** ☐ **MODERATE FAT** ☐ **HIGH FAT**

WHAT KIND OF WORK DO YOU DO? _____

WHO WAS YOUR PREVIOUS PHYSICIAN? _____

ANY HAZARDOUS HABITS? _____

ANY USE OF ILLICIT OR RECREATIONAL DRUGS? _____

WHAT IS YOUR SEXUAL ORIENTATION? _____

WHO LIVES WITH YOU? _____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS?

	MEDICINE	REACTION YOU HAD	YEAR
1.			
2.			
3.			

HAVE YOU EVER HAD A BLOOD TRANSFUSION? **YES NO** WHAT YEAR? _____
HAVE YOU HAD THE PNEUMOVAX VACCINE? **YES NO** WHAT YEAR? _____
HAVE YOU HAD THE PCV-13 PNEUMONIA VACCINE? **YES NO** WHAT YEAR? _____
WHEN WAS YOUR LAST TETANUS SHOT? _____
HAVE YOU HAD YOUR HEPATITIS B SHOTS? **YES NO** HEPATITIS A SHOTS? **YES NO** WHAT YEAR?_____
HAVE YOU HAD COLONOSCOPY? (YEAR) _____
HAVE YOU HAD SHINGLES OR THE VACCINE? (YEAR) _____

PLEASE LIST ALL OF YOUR HOSPITALIZATIONS

	DATE	PROBLEM OR OPERATION	HOSPITAL OR CITY	DOCTOR
1				
2.				
3.				
4.				
5.				
6.				
7.				

DO YOU HAVE ANY PRESENT MEDICAL PROBLEMS?

	PROBLEM	WHEN IT BEGAN	PRESENT TREATMENT
1.			
2.			
3.			
4.			
5.			

DO YOU HAVE ANY PAST MEDICAL PROBLEMS?

	PROBLEM	YEAR	TREATMENT
1.			
2.			
3.			
4.			
5.			

PLEASE LIST ALL MEDICINES YOU ARE CURRENTLY TAKING (BOTH PRESCRIPTION AND NON-PRESCRIPTION)

	MEDICINE	DOSE	FREQUENCY	PRESCRIBED BY
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

DO YOU NOW HAVE, OR HAVE YOU EVER HAD THE FOLLOWING?

NOW	OR	WHAT YEAR	NOW	OR	WHAT YEAR
_____	_____	EYE TROUBLE	_____	_____	EAR TROUBLE
_____	_____	NOSE/SINUS TROUBLE	_____	_____	FAINTING SPELLS
_____	_____	SEIZURES	_____	_____	PARALYSIS
_____	_____	DIZZINESS	_____	_____	HEADACHES/MIGRAINES
_____	_____	THYROID DISEASE	_____	_____	SKIN DISEASE
_____	_____	COUGH	_____	_____	CHEST PAIN/ANGINA
_____	_____	SPITTING UP BLOOD	_____	_____	NIGHT SWEATS
_____	_____	SHORTNESS OF BREATH	_____	_____	SLEEP TROUBLE
_____	_____	PALPITATIONS	_____	_____	SWELLING OF LEGS/FEET
_____	_____	SEVERE TIREDNESS/WEAKNESS	_____	_____	KIDNEY STONES
_____	_____	TROUBLE URINATING	_____	_____	KIDNEY INFECTIONS
_____	_____	PROSTATE TROUBLE	_____	_____	ABNORMAL THIRST
_____	_____	CHRONIC INDIGESTION	_____	_____	ULCER
_____	_____	LIVER DISEASE/HEPATITIS	_____	_____	WEIGHT LOSS
_____	_____	COLON/BOWEL TROUBLE	_____	_____	GALL BLADDER TROUBLE
_____	_____	BLOOD IN STOOL	_____	_____	HEMORRHOIDS
_____	_____	CONSTIPATION	_____	_____	BLACK TARRY STOOLS
_____	_____	DIARRHEA	_____	_____	NIGHT VOIDING
_____	_____	DEPRESSION/BREAKDOWN	_____	_____	CHANGE IN EATING OR
_____	_____	SEXUAL FUNCTION PROBLEM			BOWEL HABITS

PAST SURGICAL HISTORY

Please list any surgeries that you have had:

☐ Appendectomy	☐ Colectomy (Colon removal)	☐ Thyroidectomy
☐ Cardiac (Heart) Bypass	☐ Gall Bladder Removal	☐ Tonsillectomy
☐ Cardiac (Heart) Stent	☐ Gastric Bypass	☐ Tubal Ligation
☐ Cataract	☐ Hip Replacement	
☐ Caesarean Section	☐ Knee Replacement	

Other (Please list): _____

_____

WOMEN ONLY

AGE AT START OF PERIODS? _____ USUAL DURATION OF FLOW? _____

CYCLE (START TO START) _____ DATE OF LAST PERIOD? _____

BIRTH CONTROL METHOD, IF ANY? _____

NUMBER OF PREGNANCIES? _____ NUMBER OF LIVING CHILDREN? _____

DATE OF LAST PAP TEST?_____ HISTORY OF ABNORMAL PAP? **YES NO**

DONE BY?_____ WHEN?_____ TREATMENT? _____

DATE OF LAST MAMMOGRAM? _____ REGULAR BREAST SELF-EXAMINATIONS? **YES NO**

DATE OF LAST BONE DENSITY STUDY?_____ RESULT?_____

1._____

_____

2._____

_____

3._____

_____