

Date: _____ Date of birth: _____

Name: _____ Alias/ Nicknames: _____

Main Reason for visit: _____

MEDICAL HISTORY: (note year diagnosed with details)

- Asthma _____
- Bladder /Kidney disorders _____
- Blood Disorders _____
- Breast / GYN disorders _____
- Cancer (_____) _____
- Chronic eye/ear/nose disorders _____
- Depression/anxiety _____
- Diabetes _____
- Gastrointestinal disorders _____
- Heart disorders _____
- High blood pressure _____
- High Cholesterol _____
- Lung/COPD/Emphysema _____
- Neurologic/ Stroke/ Seizure _____
- Prostate Problems _____
- Skin disorders _____
- Thyroid disorders _____
- Others _____

SURGERIES (major) (Note Year)

- Abdominal _____
- Appendix _____
- Breast _____
- Gall bladder _____
- Heart _____
- Orthopedic _____
- Prostate _____
- Uterus / Ovary _____
- Other _____

Other Concerns:

Weight: Is your weight a concern? Yes No

Diet: How do you rate your diet? Good Fair Poor

Exercise: Do you exercise regularly? Yes No

What kind of exercise? _____

How long (minutes) _____ How often? _____

Safety: Is violence at home a concern for you? Yes No

Have you ever been abused? Yes No

Do you fall frequently? Yes No

Have you completed a living will or durable power of attorney for health care? Yes No

SOCIAL HISTORY:

Single Married Widowed Divorced Separated

Children: None 1 2 3 4 5

Occupation: _____

Years of education/highest degree: _____

Tobacco Use:

Cigarettes: Never Quit year _____

Current smoker: packs/day ____ # of years _____

Other Tobacco: pipe cigar snuff chew

Are you interested in quitting? Yes No

Drink caffeine: Yes No Cups per day _____

Alcohol Use: Yes No # drinks/week _____

Is your alcohol a concern for you or others?

Yes No

Drug Use:

Have you used any recreational drugs? Yes No

Have you ever used needles to inject drugs?

Yes No

Sexual Activity:

Sexually active: Yes No Not currently

Current sex partner(s): Male Female

Birth Control method: _____ none needed

Have you ever had a sexually transmitted disease(s) (STD's)? Yes No

Are you interested in being screened for sexually transmitted diseases? Yes No

PAST TESTS:

Year last done

Bone Density Scan Y N _____

Colonoscopy Y N _____

Mammogram Y N _____

PAP test (female) Y N _____

PSA (prostate) Y N _____

Treadmill (heart) Y N _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

| MEDICATION | DOSE | TIMES PER DAY | MEDICATION | DOSE | TIMES PER DAY |
|------------|------|---------------|------------|------|---------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

PATIENT ID



PATIENT HISTORY FORM
Side 1

Name _____

MRN _____

Date of Birth _____

Date of Service _____

LABEL

ALLERGIES OR REACTIONS TO MEDICINES / FOOD / OTHER AGENTS:

| MEDICATION | REACTION OR SIDE EFFECT | DATE |
|------------|-------------------------|------|
| | | |
| | | |
| | | |

FAMILY HISTORY:

| Check all that apply | Mental Health Disorders | Alcohol Abuse | CANCER | | | | Diabetes | Heart Disease | High Blood Pressure | High Cholesterol | Cause of death or major illness | ADULT IMMUNIZATIONS: Please note if you have had any of the following immunizations (Note Year) (Year) |
|----------------------|-------------------------|---------------|--------|-------|----------|------|----------|---------------|---------------------|------------------|---------------------------------|--|
| | | | Breast | Colon | Prostate | Lung | | | | | | |
| Father | | | | | | | | | | | | Gardasil Y N _____ |
| Mother | | | | | | | | | | | | Hepatitis B: Y N _____ |
| Maternal Grandfather | | | | | | | | | | | | Influenza (yearly): Y N _____ |
| Maternal Grandmother | | | | | | | | | | | | Pertussis: Y N _____ |
| Paternal Grandfather | | | | | | | | | | | | Pneumonia: Y N _____ |
| Paternal Grandmother | | | | | | | | | | | | Shingles: Y N _____ |
| Brothers | | | | | | | | | | | | Tetanus: Y N _____ |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Sisters | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

WOMEN: MEN:

Date of last menstrual period: _____
 # of pregnancies: _____ # of children: _____
 Pap smears: normal Date _____ abnormal Date _____
 Mammogram: normal abnormal

Do you take any of the following:
 Calcium: Yes No Past
 Vitamin D: Yes No Past
 Estrogen (Premarin): Yes No Past
 Progesterone (Provera): Yes No Past

Do you have any of the following problems:
 Waking up at night to urinate? Yes No
 Difficulty starting urine stream? Yes No
 Sexual concerns (getting or keeping an erection) Yes No
 Have you had an abnormal PSA test? Yes No

Comments:



**PATIENT HISTORY FORM
 Side 2**

PATIENT ID

Name _____
 MRN _____
 Date of Birth _____
 Date of Service _____

