

PATIENT HISTORY FORM

NAME		DATE OF BIRTH	TODAY'S DATE																					
OCCUPATION		MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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.																								
<table style="width: 100%; border: none;"> <tr> <td style="width: 12.5%;">Alcoholism</td> <td style="width: 12.5%;">Arthritis</td> <td style="width: 12.5%;">Cancer</td> <td style="width: 12.5%;">Gout</td> <td style="width: 12.5%;">Kidney disease</td> <td style="width: 12.5%;">Mental Illness</td> <td style="width: 12.5%;">Seizures</td> </tr> <tr> <td>Allergies/Hay Fever</td> <td>Birth defects</td> <td>Diabetes</td> <td>Heart disease</td> <td>Liver disease</td> <td>Migraines</td> <td>Stroke</td> </tr> <tr> <td>Anemia</td> <td>Bleeds easily</td> <td>Glaucoma</td> <td>Hypertension</td> <td>Lung disease</td> <td>Osteoporosis</td> <td>Thyroid disease</td> </tr> </table>				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
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Spouse:		Brothers:																						
Mother:																								
Father:		Sisters:																						
Children:																								
MEDICATIONS: List all medications that you are now taking. Please include vitamins and herbs.																								
1.	dosage:	frequency:	8.																					
2.	dosage:	frequency:	9.																					
3.	dosage:	frequency:	10.																					
4.	dosage:	frequency:	11.																					
5.	dosage:	frequency:	12.																					
6.	dosage:	frequency:	13.																					
7.	dosage:	frequency:	14.																					
PAST MEDICAL HISTORY: Please check (✓) any conditions you have or have had in the past																								
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DRUG ALLERGIES OR ALLERGIC REACTION TO MEDICATION OR SUBSTANCE: <i>i.e.</i> , 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 hemocult: _____ 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