Patient History Form

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Name: _____DOB: _____ Date: _____

What is the major reason for today's visit? _____

Personal History

Birthplace_____
Race _____
Marital Status_____
Occupations _____Disabled_____
Street Drugs_____
Recreation/Hobbies_____
Exercise_____How Often_____
Pets _____
Alcohol _____
Tobacco ____How Long___ Packs Per Day___
Tea, Soda, Coffee_____
Traveling outside the country ____When_____
Exposure to Toxic Chemicals (Radiation, Chemo, Asbestos, Other) _____

Medical History

*Have you had any of the following? **Circle those which apply and give dates** where appropriate.*

Measles/Mumps	Hay fever/sinusitis
Whooping Cough	Polio
Scarlet fever	Diphtheria
Meningitis	Infectious Mono
Valley Fever	Tuberculosis
Exposure to TB	Skin test positive to TB
Malaria	Hives
Pneumonia	Bronchitis
Pleurisy	Asthma
Emphysema	Rheumatic Fever
Arthritis	Back Trouble
Cancer Type_____	
Venereal disease	Glaucoma
High blood pressure	COPD
Heart disease	OSA
Heart attack/Stroke	Asthma-Age___
Diabetes Juvenile	Emphysema
Diabetes adult onset	Chronic Bronchitis
Narcolepsy	Pulmonary Fibrosis
Seizure	Lung Cancer
Anemia	Cystic Fibrosis
Bleeding Tendency	Blood transfusion
Hepatitis (yellow jaundice)	Nose bleeds
Hemorrhoids	Ulcer
Bladder infections	Kidney disease

Surgical History

*Have you had any of the following operations? **Circle those which apply and give dates** where appropriate.*

Heart/Cath/Stent/Pacemaker
Coronary bypass surgery
Heart valve replacement
Tonsils
Appendix
Gall bladder
Stomach
Breast
Uterus and /or ovary
Prostate
Hernia
Thyroid
Varicose
Veins
Hemorrhoids
Other _____

Injury History

*Have you had any of the following injuries**? Circle those which apply and give dates** where appropriate.*

Head
Chest
Abdomen
Broken Bones
Back
Other _____

Allergies

*Have you had allergies to any of the following? **Circle or complete which apply***

Tetanus antitoxin
Penicillin
Sulfa
Other drugs _____
Foods
Other _____

Immunizations

Have you had the following immunizations? ***Circle those which apply and give dates*** *where appropriate.*

Smallpox
Tetanus
Polio
Flu shot
Pneumovax
Other_____

Family History

Do you have a family history of any of the following medical conditions? ***Circle those which apply and list relationship.***

Anemia	COPD
Bleeding Tendency	OSA
Leukemia	Asthma
Repeated infections	Pulmonary Fibrosis
Crippling infections	Cystic Fibrosis
Heart disease	Lung Cancer
Chronic lung disease	Emphysema
Tuberculosis	Chronic Bronchitis
High blood pressure	Narcolepsy
Kidney disease	Diabetes
Asthma	Severe allergies
Mental illness	Gout
Convulsions	Obesity
Migraine headaches	Thyroid trouble
Peptic ulcer	Chronic diarrhea
Cancer	

Father □ Alive □ Deceased Age _____
Causes of death _____
Mother □ Alive □ Deceased Age _____
Causes of death _____

Systems Review

Have you recently had the following?

General	**Yes**	**No**
Tire easily	☐	☐
Weakness	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
Sensitivity to heat	☐	☐
Sensitivity to cold	☐	☐
Weight Loss	☐	☐
Weight Gain	☐	☐
Skin		
Rash	☐	☐
Change in color	☐	☐
Change in hair	☐	☐
Change in nails	☐	☐

Eyes	**Yes**	**No**
Trouble seeing	☐	☐
Eye pain	☐	☐
Inflamed eyes	☐	☐
Double vision	☐	☐
Worn glasses	☐	☐
Ears		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
Discharge from ears	☐	☐
Nose		
Loss of smell	☐	☐
Frequent colds	☐	☐
Obstruction	☐	☐
Excess discharge	☐	☐
Nosebleeds	☐	☐
Mouth		
Sore gums	☐	☐
Soreness of tongue	☐	☐
Dental problems	☐	☐
Throat		
Postnasal drainage	☐	☐
Soreness	☐	☐
Hoarseness	☐	☐
Change in voice	☐	☐
Breasts		
Lumps	☐	☐
Discharge	☐	☐
Heart		
Chest pain	☐	☐
Palpitations	☐	☐
Short of breath while lying	☐	☐
High blood pressure	☐	☐
Vein problems	☐	☐
Lungs		
Cough	☐	☐
Sputum (phlegm)	☐	☐
Bloody sputum	☐	☐
Wheezing	☐	☐
Pain on breathing in chest	☐	☐
Shortness of breath	☐	☐
SOB with exertion	☐	☐
Swelling in ankles	☐	☐
Bluish fingers or lips	☐	☐

Abdomen	**Yes**	**No**
Change in appetite	☐	☐
Difficulty in swallowing	☐	☐
Heartburn	☐	☐
Belching	☐	☐
Excess gas	☐	☐
Enlargement	☐	☐
Nausea/Vomiting	☐	☐
Vomiting blood	☐	☐
Rectal bleeding	☐	☐
Bloody stools	☐	☐
Dark urine	☐	☐
Jaundice	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Hemorrhoids	☐	☐
Need for laxatives	☐	☐
Kidney and Urinary		
Increase in urination at night	☐	☐
Unable to hold urine	☐	☐
Impotence	☐	☐
Lack of sex drive	☐	☐
Pain with intercourse	☐	☐
Endocrine		
Thyroid nodule or mass	☐	☐
High thyroid level	☐	☐
Low thyroid level	☐	☐
Adrenal trouble	☐	☐
High blood sugars	☐	☐
Low blood sugars	☐	☐
Muscular		
Muscle cramps	☐	☐
Muscle weakness	☐	☐
Pain in joints	☐	☐
Swollen joints	☐	☐
Joint stiffness	☐	☐
Deformity of joints	☐	☐
Nervous System		
Headaches	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Convulsions or seizures	☐	☐
Nervousness	☐	☐
Depression	☐	☐
Change in sensation	☐	☐
Memory loss	☐	☐
Poor coordination	☐	☐
Weakness	☐	☐
Paralysis	☐	☐

Sleep Disorders	**Yes**	**No**
Snoring	☐	☐
Excessive daytime sleepiness	☐	☐
Pauses in breathing during sleep	☐	☐
Insomnia	☐	☐
Sleeplessness	☐	☐
Sleepiness while driving	☐	☐
Gyn-OB		
Pregnant_____		