

PATIENT HISTORY FORM

Fax to 4451

Name: _____ DOB: _____ Age: _____

Reason for Visit: _____

Allergies: _____

Medications: *Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc)*

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Review of Systems: Do you have?

- | | | | |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Reflux | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Skin Lesion | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chronic Headache | <input type="checkbox"/> Seizures | <input type="checkbox"/> Frequent Urination |
| | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression | <input type="checkbox"/> Asthma |

Past Medical History:

Do you have?

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Other _____ | |

Past Surgical History:

Have you had?

- | |
|--|
| <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> _____ |
| <input type="checkbox"/> None |

Family History:

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure Who: _____ | <input type="checkbox"/> Cancer Who: _____ |
| <input type="checkbox"/> Heart Disease Who: _____ | <input type="checkbox"/> Depression Who: _____ |
| <input type="checkbox"/> Diabetes Who: _____ | <input type="checkbox"/> Kidney Disease Who: _____ |
| <input type="checkbox"/> Osteoporosis Who: _____ | |
| <input type="checkbox"/> Other _____ <input type="checkbox"/> None | |

Social History:

- Occupation: _____
- Drugs _____
- Tobacco Use Yes No How long? _____
- Alcohol Use Yes No
- Transfusions Yes No
- Married Divorced Widowed

Health Maintenance:

- | | | | |
|-----------------|--------------|----------|--------------|
| | Date of last | | Date of last |
| Last Pap/Pelvic | _____ | Eye Exam | _____ |
| Mammogram | _____ | Tetanus | _____ |
| Rectal | _____ | Flu | _____ |
| Pneumovax | _____ | Other | _____ |
| PSA | _____ | | |
| Colonoscopy | _____ | | |