

Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Last Name _____ First Name _____ DOB _____
 Date _____

Review of Systems

Do you now or have you had any problems related to the following systems? **(Please Use Black Ink)**

Circle Yes or No

Constitutional Symptoms	Comments	Musculoskeletal	Comments
Weight change	Y N	Bone Pain	Y N
Chills/Fever	Y N	Muscle Pain	Y N
Sleep Disorder	Y N	Joint Pain	Y N
Eyes		Integumentary (skin)	
Double Vision	Y N	Rash	Y N
Glaucoma	Y N	Lumps or Bumps	Y N
Cataracts	Y N	Moles, Skin Tags	Y N
Ear/Nose/Throat/Mouth		Respiratory	
Hearing Changes	Y N	Wheezing	Y N
Sore Throat	Y N	Frequent cough	Y N
Sinus Problems	Y N	Shortness of Breath	Y N
Cardiovascular		Neurological	
Chest Pain	Y N	Tremors	Y N
Irregular Heartbeat	Y N	Dizzy Spells	Y N
Swelling in Ankles	Y N	Numbness/Tingling	Y N
Psychological		Gastrointestinal	
Are You generally happy?	Y N	Abdominal Pain	Y N
Do you feel depressed?	Y N	Nausea/Vomiting	Y N
Do you feel anxious?	Y N	Indigestion/Heartburn	Y N
Do you feel safe in your home?	Y N	Constipation/Diarrhea	Y N
		Other:	
Endocrine		Genitourinary	
Excessive Thirst	Y N	Urinary Incontinence (loss of urine)	Y N
Too Hot/Cold	Y N	* Spontaneous	Y N
Tired/Fatigued	Y N	* With Activity	Y N
Irregular Periods	Y N	Urinary Frequency > 8 times/day	Y N
Painful Periods	Y N	Painful Urination	Y N
Heavy Bleeding	Y N		
Bleeding after Menopause	Y N		
Hematologic/Lymphatic		Sexual History	
Swollen Glands	Y N	Have you ever been sexually active?	Y N
Blood Clotting Problems	Y N	Are you currently sexually active?	Y N
Bruising	Y N	Heterosexual or Homosexual (circle one)	
		Method of Contraception _____	
		Change in Sex Drive	Y N
		Painful Intercourse Sexual Trauma	Y N
Allergic/Immunologic			
Hay Fever	Y N	Are you done having children?	Y N
Drug Allergies	Y N		
Food allergies	Y N	Have you been vaccinated for:	
Other:		Tetanus, Diphtheria, Pertussis (Tdap)	Y N
		Hepatitis A	Y N
		Hepatitis B	Y N

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Physician Signature _____ Date _____

Medical History

Patient Name: _____

Medical <input type="checkbox"/> None (High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.) _____	Pregnancy History Year Sex Complications
_____	_____
_____	_____
_____	_____

Surgical <input type="checkbox"/> None Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.) _____	Gyn/Breast/Colon History
_____	Last Pap: _____
_____	Last Mammo: _____
_____	Colonoscopy: _____
_____	Sigmoidoscopy: _____
_____	Regular Periods? _____
_____	Length of Periods? _____
_____	Age at 1 st Period? _____

Allergies to Medications? None (If yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling etc.)

Current Prescription Medicines <input type="checkbox"/> None				Current Prescription Medicines (cont'd)			
Name of Drug	mg dose	# tablets	# times per day	Name of Drug	mg dose	# tablets	# times per day
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Family History

	Living	Deceased	Illness	Cause of death/illness
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister (s)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brother (s)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Other Family History:	Yes	No	Family Member	Yes	No	Family Member
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Smoke? Yes No If yes, # of packs per day: _____ # of years _____ When did you stop smoking? _____

Alcohol? Yes No If yes, how many drinks per week? _____

Occupation? _____

Coffee – How Much? _____ Tea – How Much? _____ Soda – How Much? _____

Have you ever used recreational drugs? (i.e. marijuana, cocaine) If yes, what/when: _____

Domestic Violence? _____
