



**PATIENT HISTORY FORM**

Your Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Previous physician: Dr. \_\_\_\_\_ Location \_\_\_\_\_

What type of complaint or disease is the reason for requesting this visit?

**SOCIAL HISTORY**

**Home situation** (circle, or add in writing):

Single \_\_\_\_\_ Married (how long \_\_\_\_\_) Divorced (how long \_\_\_\_\_) Widowed (how long \_\_\_\_\_)

Domestic partnership \_\_\_\_\_ Children? \_\_\_\_\_ Are they healthy? \_\_\_\_\_

**Employment:**

Status: full-time \_\_\_\_\_ part-time \_\_\_\_\_ retired \_\_\_\_\_ disabled \_\_\_\_\_ homemaker \_\_\_\_\_

**Occupation/type of work/jobs:** \_\_\_\_\_

**Habits:** Do you smoke? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, how many packs per day? \_\_\_\_\_  
If you have quit, how long ago? \_\_\_\_\_  
Do you use alcohol? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, how often do you drink? \_\_\_\_\_  
If you have quit, how long ago? \_\_\_\_\_  
Do family or friends worry about your alcohol intake? \_\_\_\_\_

Have you ever had problems with drug use? \_\_\_\_\_

**Religious preference** \_\_\_\_\_ **Church if any?** \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Please list other diseases from which you currently suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the past:

Please list any surgeries/procedures(operations or colonoscopy, etc), reason for the surgery, and date of surgery:

**MEDICATIONS:**

Prescription medications	Dose	How often taken

**NON-PRESCRIPTION** (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

**HERBAL PREPARATIONS**

Herbal preparation	Dose	How often taken

**ALLERGIES OR ADVERSE DRUG REACTIONS?** Please list drug and type of reaction

**FAMILY HISTORY:**

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								

Mother Alive/Deceased ? Age \_\_\_\_\_ Medical conditions \_\_\_\_\_

Father Alive/Deceased? Age \_\_\_\_\_ Medical Conditions \_\_\_\_\_

**SYMPTOM REVIEW**

**Gastrointestinal**

- poor appetite
- abdominal pain
- indigestion
- trouble swallowing
- diarrhea
- constipation
- change in bowel habits
- nausea or vomiting
- rectal bleeding or blood in stools
- history of liver disease or abnormal liver tests

**Cardiovascular**

- chest pain
- history of angina or heart attack
- history of high blood pressure
- history of irregular beat
- history of poor circulation

**Pulmonary/lungs**

- shortness of breath
- persistent cough
- coughing up blood
- asthma or wheezing

**Muscle/joint/bone**

- swelling of ankles or legs  
pain, weakness or numbness in
- arms or hands
- back or hips
- legs or feet
- neck or shoulders

**Neurologic**

- history of stroke
- blackouts or loss of consciousness

**Anything else?**

- Are you experiencing an unusually stressful situation?
- Are there any specific personal issues you would like to bring up at the time of your visit?

**Immunizations:** if YES, give approximate year given

Pneumococcal      No \_\_\_\_\_ Yes \_\_\_\_\_  
 Hepatitis A        No \_\_\_\_\_ Yes \_\_\_\_\_  
 Hepatitis B        No \_\_\_\_\_ Yes \_\_\_\_\_  
 Tetanus            No \_\_\_\_\_ Yes \_\_\_\_\_

Advanced Directive?    No \_\_\_\_\_ Yes \_\_\_\_\_    In an emergency, do you want CPR?    Ventilator?    Tube feeds?  
 Living Will?            No \_\_\_\_\_ Yes \_\_\_\_\_    (please bring a copy for our records).

**General**

- weight gain/loss of 10+ lbs during last 6 months
- poor sleep
- fever
- headache
- depression

**Eyes, ears, nose, throat**

- blurred vision
- other change in vision
- history of glaucoma or cataracts
- loss of hearing
- ringing in ears
- sinus problems
- hoarseness

**Genitourinary**

- frequent or painful urination
- blood in urine
- urinary incontinence

**Skin**

- itching
- easy bruising
- change in moles

**Endocrine**

- history of diabetes
- history of thyroid disease
- change in tolerance to hot or cold weather
- excessive thirst

**Women only**

- abnormal Pap smear
- bleeding between periods  
date of last mammogram \_\_\_\_\_

**Men only**

- PSA level?    When? \_\_\_\_\_ Results? \_\_\_\_\_