PATIENT HISTORY FORM **DATE**: _______________________________

Patient's Name: ____ **Date of Birth**: ________________________________

Briefly describe what problem brings you to the Doctor/Nurse Practitioner: ____

____

____

Allergies: ____

Medications: (Please list all medication and dose. Are you taking Coumadin, Aspirin, or Plavix?

____

____

____

____

Social History: Marital Status: Single ____ Married ____ Divorced ____ Widowed ____

Occupation: ____

Do you or have you ever used tobacco? ______________ Do you consume alcohol? _________________________

# of packages per day? ____________ # of years smoked? ______ # of drinks per week? _____________________

If Quit, When? _________________ Type of alcohol? _________________________________

<u>Past Medical History</u>: Please place a check if you have had any of the following.

Diabetes ________ Headache/Migraines _______ High Blood Pressure _______ Thyroid _______

Other: ____

____

Past Gynecological History:

Last menstrual period date: _______________________________ # of Pregnancies ____________ Live Births ______________

Pap Smear Date: ________________________ Mammogram Date: ___________________________

Surgical History: Surgery & Date

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____

Have you had a Colonoscopy? _________________ If Yes, when & by whom? ____

Immunizations: Last Tetanus Shot: ________________ Pneumonia Vaccine? ________________ Flu Shot? _______________

Singles Vaccine? _______________ If patient is a child, are Immunizations up to date? _______________

Patient's Name: ____

Family Medical History

	Age	Living	Deceased	Diseases/Cause of Death
Mother				
Father				
Sister				
Sister				
Sister				
Brother				
Brother				
Brother				
Grandmother				
Grandfather				

Do You Now or Have You Ever Had the Problems with Any of the Following?

(Please check in front of any that apply)

Constitutinal		Recent weight Change		Fever		Fatigue		Insomnia		None
Eyes		Blurred vision		Glaucoma		Cataracts		Other		None
Ears/Nose/		Hearing Loss		Ringing in ears		Mouth Sores		Trouble Swallowing		None
Mouth/Throat		Sore Throat		Runny Nose		Allergies				
Cariovascular		Chest Pain		Shortness of Breath		Swelling of ankles		Palpita-tions		None
		Irregular Heart Rate								
Respiratory		Chronic Cough		Spitting up blood		Wheezing		None		
Genitourinary		Buring w/ urination		Blood in Urine		Slow or Small Stream		Menstrual Problems		None
		Abnormal Vaginal Bleeding		Abnormal PAP Smear						
Musculoskeletal		Joint pain or swelling		Back Pain		Muscle Pain		None		
Skin		Rash		Itching		Lumps or Nodules		None		
Gastrointestinal		Poor Appetite		Difficulty Swallowing		Heartburn		Nausea or Vomiting		None
		Bloating		Belching		Regurgi-tation		Constip-ation		Diarrhea
		Abdominal Pain		Recent change in bowel habits		Rectal Bleeding		Black, Tarry Stooks		
Neurological		Headache		Seizures		Stroke(s)		Numbness		None
Psychiatric		Memory Loss or confusion		Depression		Anxiety		Suicidal Thoughts		None
Endocrine		Heat or Coldl Intolerance		Excessive thirst or urination		None				
Hematological		Bleeding or bruising		Anemia		Past Transfusion		None		