

Patient Name: \_\_\_\_\_

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

**In order to provide the best care we need to know your history. Please take a few minutes to answer all questions. Please add any information you feel will help explain your health. If you need any help with this form please ask us. Thank you.**

**PATIENT DEMOGRAPHICS AND CHIEF COMPLAINT**

Today's Date \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Who referred you to our practice? \_\_\_\_\_

Have any of your family members been treated here? \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

When did you first have this problem? \_\_\_\_\_

**General Health**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Recurrent infections | <input type="checkbox"/> Recurrent fever    | <input type="checkbox"/> Fatigue            |
| <input type="checkbox"/> Night sweats         | <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Recent weight loss |
| <input type="checkbox"/> Decreased appetite   | <input type="checkbox"/> No problems        |   |

Comments \_\_\_\_\_

**Skin**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Sores            | <input type="checkbox"/> Hair loss     | <input type="checkbox"/> Non-healing wound |
| <input type="checkbox"/> Changes in moles | <input type="checkbox"/> New lesions   | <input type="checkbox"/> Burn trauma       |
| <input type="checkbox"/> Rash             | <input type="checkbox"/> Lumps/growths | <input type="checkbox"/> No problems       |

Comments \_\_\_\_\_

**Head, Ears, Eyes, Nose, Throat**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nose bleeding      | <input type="checkbox"/> Cataracts      |
| <input type="checkbox"/> Sore throat    | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Eye infections |
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Corrective lenses  | <input type="checkbox"/> Blurred vision |
|   |   | <input type="checkbox"/> No problems    |

Comments \_\_\_\_\_

**Lung**

- |   |                                   |  |
|---|-----------------------------------|--|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Cough    | <input type="checkbox"/> Sleep with more than 1 pillow |
| <input type="checkbox"/> Cough blood or mucus | <input type="checkbox"/> Wheezing | <input type="checkbox"/> No problems                   |

Comments \_\_\_\_\_

**Breast**

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Breast lump/mass | <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> No problems |
| <input type="checkbox"/> Breast pain      | <input type="checkbox"/> Nipple pain      |                                      |
| <input type="checkbox"/> Breast swelling  | <input type="checkbox"/> Skin changes     |                                      |

Comments \_\_\_\_\_

**Heart**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chest pain      | <input type="checkbox"/> Tightness            | <input type="checkbox"/> Thumping or pounding |
| <input type="checkbox"/> Heart murmur    | <input type="checkbox"/> Swollen arms or legs | <input type="checkbox"/> Shortness of breath  |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> No problems          |

Comments \_\_\_\_\_

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**Stomach and Intestinal**

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> Special diet          | <input type="checkbox"/> Heartburn    | <input type="checkbox"/> Rectal bleeding    |
| <input type="checkbox"/> Nausea                | <input type="checkbox"/> Indigestion  | <input type="checkbox"/> Blood in stool     |
| <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Black stools | <input type="checkbox"/> Positive hemoccult |
| <input type="checkbox"/> Ulcers                | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diverticulosis     |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Diverticulitis     |
|  |                                       | <input type="checkbox"/> No Problems        |

Comments \_\_\_\_\_

**Male Reproductive**

- |  |                                    |  |
|--|------------------------------------|--|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Frequency | <input type="checkbox"/> Impotence       |
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Urgency   | <input type="checkbox"/> Testicular pain |
|  |                                    | <input type="checkbox"/> No problems     |

Comments \_\_\_\_\_

**Female Reproductive**

- |  |                                    |                                      |
|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Frequency | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Urgency   | <input type="checkbox"/> No problems |

Comments \_\_\_\_\_

**Muscle, Bone, Joint**

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> Joint pain  | <input type="checkbox"/> Neck pain       | <input type="checkbox"/> Muscle cramping |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> No problems     |
| <input type="checkbox"/> Back pain   | <input type="checkbox"/> Joint swelling  |  |

Comments \_\_\_\_\_

**Nervous System**

- |                                    |  |  |
|------------------------------------|--|--|
| <input type="checkbox"/> Seizures  | <input type="checkbox"/> Decreased memory      | <input type="checkbox"/> Problems speaking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Problems moving   |
|                                    | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> No problems       |

Comments \_\_\_\_\_

**Veins (blood vessels), Lymphatic**

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Easy bruising        | <input type="checkbox"/> No problems |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Enlarged lymph nodes |                                      |

Comments \_\_\_\_\_

**ALLERGIES**

Are you allergic to any medications, prescribed or over the counter?  Yes  No

If yes, please list medication and the reaction you had. (Include aspirin, Tylenol, vitamins, over the counter medications, herbal remedies, supplements etc.) \_\_\_\_\_

Are you allergic to any contacts such as latex, adhesive tape or betadine?  Yes  No

If yes, please list the contact and the reaction you had. \_\_\_\_\_

Are you allergic to any foods?  Yes  No

If yes, please list food and the reaction you had. \_\_\_\_\_

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**FAMILY HISTORY**

Are there diseases or illnesses that family members have had? Please check the boxes below for any family member who has had the problem. **Under siblings please write brother or sister. Under Grandmother please write maternal (mother) or paternal (father). Under Grandfather please write maternal (mother) or paternal (father).**

	Mother	Father	Siblings	Grandmother	Grandfather	Children	Cousins	Aunt	Uncle
Anesthetic Problems									
Cancer -Breast									
Cancer -Colon									
Cancer-Ovarian									
Cancer-Pancreatic									
Cancer-Prostate									
Cancer-Other									
Diabetes									
Heart Disease									
High Blood Pressure									
Mental Illness									
Stroke									
Tuberculosis									

Comments \_\_\_\_\_

**PAST MEDICAL HISTORY**

Do you see a doctor regularly for any medical reasons?  Yes  No

If yes, for what reason? \_\_\_\_\_

Have you had any surgery in the past?  Yes  No

If yes, please list the date and type of surgery. \_\_\_\_\_

Have you ever had a **colonoscopy**?  Yes  No

If yes, please list date and the results. \_\_\_\_\_

Have you had any serious injuries?  Yes  No

If yes, please list the date and type of injury. \_\_\_\_\_

Have you had any diseases or health problems in the past?  Yes  No

If yes, please check any of the following that you have had.

- Anemia                       Colitis                       Heart disease               High blood pressure  Lung disease
- Cancer                         Diabetes                     Hepatitis A B C             Jaundice                     Depression
- Cataracts                     Glaucoma                    AIDS                         Kidney disease             Epilepsy
- Stroke                         Headaches                 HIV                          Leukemia                    Ulcers
- High Cholesterol     Hypothyroidism     Hyperthyroidism
- Other \_\_\_\_\_

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**WOMEN'S HISTORY**

Date of first period? \_\_\_\_\_ Date of last period? \_\_\_\_\_

Number of pregnancies? \_\_\_\_\_ Number of live births? \_\_\_\_\_

Date of last pap smear? \_\_\_\_\_ What were the results? \_\_\_\_\_

Are you on hormone therapy?  Yes  No If yes, describe \_\_\_\_\_

Do you do self breast exams?  Yes  No When was your last mammogram? \_\_\_\_\_

**SOCIAL HISTORY**

What is your marital status?  Married  Single  Divorced  Widowed

What is your occupation (if retired, your past occupation)? \_\_\_\_\_

Do you smoke?  Yes  No If Yes, how much per day and how many years? \_\_\_\_\_

Have you ever smoked?  Yes  No If Yes, at what age did you quit? \_\_\_\_\_

Do you drink alcoholic drinks?  Yes  No If yes, how much and how often? \_\_\_\_\_

Do you take any drugs for reasons that are not medical?  Yes  No

If yes, please list \_\_\_\_\_

**MEDICATIONS/OVER THE COUNTER/SUPPLEMENTS**

Do you take any prescribed medicine, over the counter, non-prescribed, or health supplements?  Yes  No

**List name of medication or supplement and how much you take**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

Do you take blood thinners?  Yes  No

Do you use a C-Pap machine?  Yes  No

Do you take Metformin?  Yes  No

Do you take Glucophage?  Yes  No

Do you take Aspirin daily?  Yes  No

Do you take St. John's Wort?  Yes  No

Are you on a weight loss program?  Yes  No

**OTHER INFORMATION** Please write below any other information you feel the doctor should

**know.** \_\_\_\_\_