PERSONAL INFORMATION

Name _____ Date _____

Date of Birth _____ Age _____ Sex ( ) M ( ) F Marital Status ( )S ( ) M ( ) D ( ) W

Occupation _____ Ethnic Bachground/Race (optional) _____

ALLERGIES

Medication(s) Other than medications

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

Current Medications _____

Over-the-Counter Medications/Herbal supplements _____

Current Health Problems _____

Previous Health Problems _____

PATIENT EDUCATION ASSESSMENT

How do you best learn? ( ) Verbal ( ) Written ( ) Demonstration ( ) Other

PATIENT RIGHTS

Is there anything we need to know about your religion or culture in order to care for you ? ( ) Yes ( ) No
If yes, please explain: _____

Advance Directive

Do you have an advance directive? ( ) Yes ( ) No
If yes, do you have a
- Living Will ( ) Yes ( ) No
- Durable Power of Attorney of Healthcare ( ) Yes ( ) No
- Directive for Final Healthcare ( ) Yes ( ) No

Who is designated to make decisions for your in the event that you are unable to make them for yourself?

If you have an Advance Directive, please bring us a copy for your chart.

Hospitalizations	Description	Year	Hospital
Illness (kind)			
Surgery (kind)			
Other (reason)			

Patient Medical History

Name: _____ **Date of Birth:** _____

Date: _____

Please check **NO** or **YES** as applicable. If yes, give brief description of problem

GENERAL

NO	YES	
()	()	Weight change
()	()	Appetite change
()	()	Fever/chills
()	()	Night sweats
()	()	General weakness
()	()	Dizziness, whirling feeling, faintness

ENDOCRINE SYSTEM

()	()	Heat or cold intolerance
()	()	Thyroid problems
()	()	History of neck surgery or irradiation

EYES

()	()	Failing vision/blind
()	()	Cataracts
()	()	Double vision
()	()	Pain
()	()	Glasses

EAR, NOSE, THROAT

()	()	Difficulty hearing/deaf
()	()	Ringing in ears
()	()	Nose bleed
()	()	Hoarseness

ADDITIONAL INFORMATION

GU SYSTEM

NO	YES	
()	()	Frequency of passing urine
()	()	Urgency in passing urine
()	()	Pass urine at night
()	()	Abnormal urine color
()	()	Blood in urine
()	()	History of kidney stones

LUNG

()	()	Shortness of breath
()	()	Shortness of breath on exertion
()	()	Sit up to breathe
()	()	Get up after going to sleep breathe
()	()	Cough; how long?
()	()	Phlegm; volume, color odor, viscosity
()	()	Cough blood
()	()	Wheezing
()	()	Blueness in lips or fingertips
()	()	Asthma history
()	()	Pneumonia history
()	()	History of tuberculosis
()	()	Exposure to tuberculosis
()	()	Skin test for tuberculosis Positive or Negative
()	()	Chest X-Ray in last year
()	()	History of respiratory infections, give frequency

Patient Medical History Page 2

Name:_____ **Date of Birth:**_____

Date:_____

GASTROINTESTINAL SYSTEM

NO	YES
()	() Nausea
()	() Vomiting
()	() Difficulty in swallowing
()	() Indigestion/heartburn
()	() Abdominal pain
()	() Jaundice
()	() Black Stool
()	() Inability to control stool
()	() Diarrhea
()	() Constipation
()	() Hemorrhoids
()	() Hernia
()	() Ulcer disease history
()	() Gall Bladder disease
()	() Pancreatitis History

MALE GENITALIA

()	() Stream size & force decrease
()	() Hesitancy
()	() Inability to hold urine (stress, urge, dribbling)
()	() History of renal disease
()	() Impotence

FEMALE GENITALIA

Last menstrual period _____

PSYCHOLOGICAL

()	() Insomnia
()	() Anxiety/Anxiousness
()	() Panic Attacks
()	() Depression
()	() Other

HEART AND BLOOD VESSELS

NO	YES
()	() Chest discomfort/pain
()	() Fainting spell
()	() Palpitations
()	() Swelling of ankles
()	() Pain in legs, calves or feet while walking
()	() Hypertension history
()	() Heart murmur history
()	() Rheumatic fever history

NERVOUS SYSTEM

()	() Headaches
()	() Loss of conciousness
()	() Seizures
()	() Stroke History

BLOOD

()	() Abnormal bleeding/ bruising
()	() Anemia
()	() Transfusions
()	() Family history of sickle cell

MUSCULOSKELETAL SYSTEM

()	() Joint stiffness
()	() Joint pain
()	() Joint swelling
()	() Muscle weakness
()	() Backache

NAME: _____ Date Of Birth _____

FAMILY HISTORY

	Living	Deceased	List any significant health problems, If deceased, list cause.
Father	☐	☐	_____
Mother	☐	☐	_____
Siblings	☐	☐	_____
	☐	☐	
	☐	☐	Date of Birth:_____
Children	☐	☐	Date of Birth:_____
	☐	☐	Date of Birth:_____
	☐	☐	_____
Maternal grandmother	☐	☐	_____
Maternal grandfather	☐	☐	_____
Paternal grandmother	☐	☐	_____
Paternal grandfather	☐	☐	

Is there any family history of:

Heart Disease	☐ Yes	☐ No						
Hypertension	☐ Yes	☐ No	Who?____	Stroke	☐ Yes	☐ No	Who?_____	
Mental Disorder	☐ Yes	☐ No	Who?____	Cancer	☐ Yes	☐ No	Who?_____	
Diabetes	☐ Yes	☐ No	Who?____	Alcoholism	☐ Yes	☐ No	Who?_____	
Breast Cancer	☐ Yes	☐ No	Who?____	Kidney Dis	☐ Yes	☐ No	Who?_____	

PERSONAL HABITS

	Yes	No	If yes how much/how often?
Do you smoke?	☐	☐	_____
Have you ever smoked?	☐	☐	_____
Do you chew tobacco?	☐	☐	_____
Do you drink alcohol?	☐	☐	_____
Do you use drugs?	☐	☐	_____
Do you exercise regularly	☐	☐	_____
Do you use seat belts?	☐	☐	_____
Any firearms in house?	☐	☐	_____
Are you or have you been a vicitm of physical or mental abuse	☐	☐	_____

FOR WOMEN ONLY

Menstrual Periods:
Age onset:_____ Regular ☐ Yes ☐ No

Date of last mestrual period_____
Difficulty with periods Yes ☐ No
Specify_____
_____
Age of Menopause_____

Lumps or discharge from breast? ☐ Yes ☐ No

Pregnancies:
Live Birth_____ Caesarian_____
Premature_____ Miscarriages_____
Do you use birth control pills ☐ Yes ☐ No
Do you practice breast exams ☐ Yes ☐ No

Date of last PAP smear_____
Date of last mammogram_____

FOR MEN ONLY

Self exam on testes ☐ Yes ☐ No