

**PATIENT HISTORY FORM**

**PERSONAL INFORMATION:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Remarried

Occupation: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

List people in your household, relationship and year of birth:

_____	_____	_____
_____	_____	_____
_____	_____	_____

**DRUG ALLERGIES/ADVERSE DRUG REACTIONS/OTHER ALLERGIES:**

_____	_____	_____
_____	_____	_____

**CURRENT MEDICAL HISTORY:**

How do you rate your present health status? \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

What do you regard as your main medical problem(s)? \_\_\_\_\_  
\_\_\_\_\_

Please list all prescriptions or over-the-counter medications with dose and frequency taken including vitamins and herbs:  
*Example: Motrin 400mg 3times a day:*

_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any other source of health care (physician clinic, urgent care, laboratory, radiology, therapist, chiropractor, etc...)

<u>Date</u>	<u>Provider or Site</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patients Initials: \_\_\_\_\_

Provider Initials: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_

<u>PERSONAL HABITS</u>	YES	NO	PREVIOUS	
Do you wear seatbelts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ times/wk Type: _____
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ packs/day Number of years: _____
Do you chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ packs/day Number of years: _____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ drinks/day Number of years: _____
Do you drink caffeine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ drinks/day Number of years: _____
Do you experience difficulty with drugs, alcohol or other substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, specify: _____

<u>Have you ever had:</u>	YES	NO	Any additional information:
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	_____
I.V. Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unsafe Sex	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

**PAST MEDICAL HISTORY:**

- Indicate any operations you have had and the year performed:  
\_\_\_\_\_  
\_\_\_\_\_
- Indicate all hospitalizations you have had for non-surgical illnesses and give the year hospitalized if possible:  
\_\_\_\_\_  
\_\_\_\_\_
- Indicate any major adult or childhood illnesses with the year of the illness:  
\_\_\_\_\_  
\_\_\_\_\_

4. If you have had any of the following, please check and indicate date if possible:

	<u>Date</u>		<u>Date</u>		<u>Date / Results</u>
Physical Exams	_____	Dental Exam	_____	EKG	_____ / _____
Tetanus shot	_____	Eye Exam	_____	Stress Test	_____ / _____
Flu shot	_____	Rectal Exam	_____	Blood Pressure	_____ / _____
PSA	_____	Pneumonia shot	_____	Cholesterol	_____ / _____
Rubella Shot	_____	Hepatitis Shot	_____	Sigmoidoscopy	_____ / _____

Patients Initials: \_\_\_\_\_  
Patient History Form  
Rev. 01/28/04

Provider Initials: \_\_\_\_\_

**PLEASE COMPLETE ALL FOUR PAGES OF THIS FORM**

Patient Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_

**FAMILY HISTORY:** Please give approximate date of onset of each disease, if known:

	Father	Mother	Bro <input type="checkbox"/> Sis <input type="checkbox"/>	Bro <input type="checkbox"/> Sis <input type="checkbox"/>	Bro <input type="checkbox"/> Sis <input type="checkbox"/>	Bro <input type="checkbox"/> Sis <input type="checkbox"/>
Year of Birth						
Year of Death						
Cause of Death						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Anemia						
Stroke						
Diabetes						
Cancer (type)						
Kidney Disease						
Asthma						
Tuberculosis						
Migraines						
Alcohol Abuse						
Drug Abuse						
Mental Problems						
Other:						
Other:						

**FOR WOMEN ONLY:**

Date of last menstrual period: \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_

Difficulty with periods? \_\_\_ Y \_\_\_ N

Number of live births: \_\_\_\_\_

Describe: \_\_\_\_\_

If menopausal, date of onset: \_\_\_\_\_

Changes in menstrual pattern? \_\_\_ Y \_\_\_ N

Date of last mammogram: \_\_\_\_\_

Describe: \_\_\_\_\_

Do you practice breast self exam? \_\_\_ Y \_\_\_ N

When was your last Pap Smear? \_\_\_\_\_

What is your method of birth control? \_\_\_\_\_

**FOR MEN ONLY:**

Do you practice testicular self-exams? \_\_\_ Y \_\_\_ N Need Instruction: \_\_\_\_\_

Have you ever had a Prostate Screening Test? \_\_\_ Y \_\_\_ N Date: \_\_\_\_\_

What method of birth control do you use? \_\_\_\_\_

Patients Initials: \_\_\_\_\_

Provider Initials: \_\_\_\_\_

**PLEASE CHECK ANY RECENT OR RECURRING PROBLEMS YOU HAVE EXPERIENCED:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Abdominal Pain    | <input type="checkbox"/> Difficulty Swallowing     | <input type="checkbox"/> Heartburn              |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Joint Pain                | <input type="checkbox"/> Chest Pain             |
| <input type="checkbox"/> Rapid Heart Rate  | <input type="checkbox"/> Wheezing                  | <input type="checkbox"/> Cough                  |
| <input type="checkbox"/> Fever             | <input type="checkbox"/> Swollen Glands            | <input type="checkbox"/> Shortness of Breath    |
| <input type="checkbox"/> Skin Rash         | <input type="checkbox"/> Swelling of Extremities   | <input type="checkbox"/> Difficulty Sleeping    |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Reaction to Anesthesia |
| <input type="checkbox"/> Lack of Energy    | <input type="checkbox"/> Constipation              | <input type="checkbox"/> Nausea                 |
| <input type="checkbox"/> Hay Fever         | <input type="checkbox"/> Nasal Congestion          | <input type="checkbox"/> Headaches              |
| <input type="checkbox"/> Problem Hearing   | <input type="checkbox"/> Vision Problems           | <input type="checkbox"/> Dizziness              |
| <input type="checkbox"/> Fainting          | <input type="checkbox"/> Abnormal Vaginal Bleeding | <input type="checkbox"/> Rectal Bleeding        |
| <input type="checkbox"/> Bleeding          | <input type="checkbox"/> Pelvic Pain               | <input type="checkbox"/> Hot Flashes            |
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Poor Appetite             | <input type="checkbox"/> Burning w/Urination    |
| <input type="checkbox"/> Weight Gain       | <input type="checkbox"/> Weight Loss               | <input type="checkbox"/> Diarrhea               |
| <input type="checkbox"/> Chills            | <input type="checkbox"/> Unsafe work conditions    | <input type="checkbox"/> Sexual Difficulties    |
| <input type="checkbox"/> Violence at home  | <input type="checkbox"/> Hazardous work or hobbies |   |

**COMMUNICATION NEEDS:**

Language if other than English: \_\_\_\_\_

Vision:       Normal     Glasses     Contacts     Blind

Hearing:     Normal     Hard of Hearing     Hearing Aid     Deaf

Interpreter Needed:     Y     N

Did someone else fill out this form?     Y     N    Who? \_\_\_\_\_

**PATIENT RIGHTS:**

Is there anything we need to know about your religion or culture in order to care for you?     Y     N

If YES, explain: \_\_\_\_\_

**ADVANCE DIRECTIVES:**

Do you have an Advance Directive:     Y     N

If YES, do you have:

- |  |   |
|--|---|
| Living Will                              | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Durable Power of Attorney for Healthcare | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Directive for Final Healthcare           | <input type="checkbox"/> Y <input type="checkbox"/> N |

Who would you want to make decisions for you in the event you are unable to make them for yourself? \_\_\_\_\_

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

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_