PATIENT HISTORY FORM

NAME: ____ AGE________ DATE:_____________

[ ] New Patient [ ] Consult [ ] Self-Referred Family Doctor ________________________________

Referred By: _________________________________

CHIEF COMPLAINT:____

HPI:____

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MEDICAL HISTORY

(Please check any of the following if you have had any problems)

[ ] Heart Attack [ ] Pneumonia [ ] Hepatitis [ ] High Blood Pressure

[ ] High Cholesterol [ ] Stroke [ ] Kidney Disease [ ] Blood Clots

[ ] Heart Disease [ ] Diabetes [ ] HIV/AIDS [ ] Bleeding Disorder

[ ] Chest Pain [ ] Asthma [ ] Emphysema [ ] Shortness of Breath

[ ] Ulcers/Bleeding [ ] Stomach [ ] Thyroid Disease [ ] Blood Transfusions

Other____

FAMILY HISTORY

Any family history of the following problems? (Mother, Father, Brother, Sister)

[ ] Stroke [ ] High Blood Pressure [ ] Diabetes [ ] Heart Disease

[ ] Cancer: What type of cancer?___________________

Who?____

PAST SURGICAL HISTORY

[ ] Hernia [ ] Appendix [ ] Gallbladder [ ] Colon [ ] Cancer

Other

____

SOCIAL HISTORY

Marital Status: [ ] married [ ] single [ ] divorced [ ] widowed

What is (was) your main occupation: _______________________________

Alcohol ? yes no How many drinks a week?______

Use Tobacco Products? [ ] yes or [ ] no

ALLERGIES [ ] None [ ] Sulfa [ ] Penicillin [ ] Tape [ ] Iodine

Other____

MEDICATIONS [ ] None

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PATIENT HISTORY FORM

NON-PRESCIPTION MEDS/HERBAL SUPPLEMENTS: [ ] None

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REVIEW OF SYSTEMS

HEENT
- [ ]Any eye disease, sight impairment
- [ ]Glasses
- [ ]Ear disease, hearing impairment
- [ ] Hearing aid R or L

CNS
- [ ]Loss of consciousness
- [ ]Convulsions
- [ ]Paralysis
- [ ]Frequent headaches

CARDIOPULMONARY
- [ ]Chronic or frequent cough
- [ ]Chest pain or angina pectoris
- [ ]Spitting up blood
- [ ]Heart Attack
- [ ]Shortness of Breath
- [ ]Palpitation or fluttering heart
- [ ]Swelling of feet, ankles
- [ ]Varicose veins

CONSTITUTIONAL
- [ ]Fever
- [ ]Nausea
- [ ]Weight Changes

GENITOURINARY
- [ ]Prostate enlargement
- [ ]Kidney disease/stones
- [ ]Bladder disease
- [ ]Difficulty urinating

NEUROMUSCULAR
- [ ]Stroke
- [ ]Weakness in arms or legs
- [ ]Muscle spasms or cramps

ENDOCRINE
- [ ]Enlarged glands
- [ ]Enlarged Thyroid or goiter
- [ ]Skin disease
- [ ]Breast Problems

GASTROINTESTINAL
- [ ]Stomach trouble or ulcers
- [ ]Indigestions
- [ ]Liver or gallbladder disease
- [ ]Colitis or other bowel disease
- [ ]Hemorrhoids or rectal bleeding

______________________________ PRINT NAME

______________________________ SIGNATURE

NOTE:
This is a confidential record of your medical history and will be kept in this office. Information contained herein will not be released to any person except with your authorization.