Date: ______________________ Date of birth: ______________________

Name: ______________________ Alias/ Nicknames: ______________________

Main Reason for visit: ______________________

MEDICAL HISTORY: (note year diagnosed with details)

- ☐ Asthma ______________
- ☐ Bladder /Kidney disorders ______________
- ☐ Blood Disorders ______________
- ☐ Breast/GYN disorders ______________
- ☐ Cancer (__________) ______________
- ☐ Chronic eye/ear/nose disorders ______________
- ☐ Depression/anxiety ______________
- ☐ Diabetes ______________
- ☐ Gastrointestinal disorders ______________
- ☐ Heart disorders ______________
- ☐ High blood pressure ______________
- ☐ High Cholesterol ______________
- ☐ Lung/COPD/Emphysema ______________
- ☐ Neurologic/ Stroke/ Seizure ______________
- ☐ Prostate Problems ______________
- ☐ Skin disorders ______________
- ☐ Thyroid disorders ______________
- ☐ Others ______________

SURGERIES (major) (Note Year)

- ☐ Abdominal __________
- ☐ Appendix __________
- ☐ Breast __________
- ☐ Gall bladder __________
- ☐ Heart __________
- ☐ Orthopedic __________
- ☐ Prostate __________
- ☐ Uterus / Ovary__________
- ☐ Other __________

Other Concerns:

Weight: Is your weight a concern? ☐ Yes ☐ No

Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Exercise: Do you exercise regularly? ☐ Yes ☐ No

What kind of exercise?______________________

How long (minutes) __________ How often? __________

Safety: Is violence at home a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Do you fall frequently? ☐ Yes ☐ No

Have you completed a living will or durable power of attorney for health care? ☐ Yes ☐ No

SOCIAL HISTORY:

Single Married Widowed Divorced Separated

Children: None 1 2 3 4 5

Occupation:______________________

Years of education/highest degree: __________

Tobacco Use:

Cigarettes: ☐ Never ☐ Quit year __________

☐ Current smoker: packs/day ____ # of years _______

Other Tobacco: ☐ pipe ☐ cigar ☐ snuff ☐ chew

Are you interested in quitting? ☐ Yes ☐ No

Drink caffeine: ☐ Yes ☐ No Cups per day_______

Alcohol Use: ☐ Yes ☐ No # drinks/week_______

Is your alcohol a concern for you or others? ☐ Yes ☐ No

Drug Use:

Have you used any recreational drugs? ☐ Yes ☐ No

Have you ever used needles to inject drugs? ☐ Yes ☐ No

Sexual Activity:

Sexually active: ☐ Yes ☐ No ☐ Not currently

Current sex partner(s): ☐ Male ☐ Female

Birth Control method: __________ ☐ none needed

Have you ever had a sexually transmitted disease(s) (STD's)? ☐ Yes ☐ No

Are you interested in being screened for sexually transmitted diseases? ☐ Yes ☐ No

PAST TESTS:			Year last done
Bone Density Scan	Y	N	
Colonoscopy	Y	N	
Mammogram	Y	N	
PAP test (female)	Y	N	
PSA (prostate)	Y	N	
Treadmill (heart)	Y	N	

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

MEDICATION	DOSE	TIMES PER DAY	MEDICATION	DOSE	TIMES PER DAY

PATIENT ID

Name ______________________

MRN ______________________

Date of Birth ______________________

Date of Service ______________________

PATIENT HISTORY FORM

293443 (7/12)

ALLERGIES OR REACTIONS TO MEDICINES / FOOD / OTHER AGENTS:

MEDICATION	REACTION OR SIDE EFFECT	DATE

FAMILY HISTORY:

Check all that apply	Mental Health Disorders	Alcohol Abuse	CANCER: Breast	CANCER: Colon	CANCER: Prostate	CANCER: Lung	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Cause of death or major illness	**ADULT IMMUNIZATIONS: Please note if you have had any of the following immunizations (Note Year)** **(Year)**
Father												Gardasil Y N ________
Mother												Hepatitis B: Y N ________
Maternal Grandfather												Influenza (yearly): Y N ________
Maternal Grandmother												Pertussis: Y N ________
Paternal Grandfather												Pneumonia: Y N ________
Paternal Grandmother												Shingles: Y N ________
Brothers												Tetanus: Y N ________
Sisters												

WOMEN:

Date of last menstrual period: ____________________

# of pregnancies: ________ # of children:__________

Pap smears: ☐ normal Date_____ ☐ abnormal Date_____

Mammogram: ☐ normal ☐ abnormal

Do you take any of the following:

Calcium: ☐ Yes ☐ No ☐ Past

Vitamin D: ☐ Yes ☐ No ☐ Past

Estrogen (Premarin): ☐ Yes ☐ No ☐ Past

Progesterone (Provera): ☐ Yes ☐ No ☐ Past

MEN

Do you have any of the following problems:

Waking up at night to urinate? ☐ Yes ☐ No

Difficulty starting urine stream? ☐ Yes ☐ No

Sexual concerns (getting or keeping an erection) ☐ Yes ☐ No

Have you had an abnormal PSA test? ☐ Yes ☐ No

Mental Well-being: Have you felt down, depressed or hopeless during the past month? ☐ Yes ☐ No

Often having little pleasure in doing things during past month? ☐ Yes ☐ No

Have you had difficulty doing common tasks lately? ☐ Yes ☐ No

Have you struggled recalling familiar words? ☐ Yes ☐ No

Rate your overall stress level: ☐ low ☐ medium ☐ high

Comments:

____

____

____

____

____

PATIENT ID

Name ____________________________________

MRN ____________________________________

Date of Birth ____________________________________

Date of Service ____________________________________

PATIENT HISTORY FORM

293443 (7/12)