

PATIENT HISTORY FORM

Today's Date _____

Name _____ Allergies to Medications: _____
(including non Prescription)

DOB _____ ID# _____

Medications (incl OTC and supplements) I am taking are: _____

Personal Medical History

- Do you have or have you had: (Please mark only the positives) Cancer Heart Problems Asthma Stroke Leukemia Cataracts
Diabetes Epilepsy Nervous Breakdown Ulcers Rheumatic Fever Bad Headaches Jaundice Colitis Kidney Disease
Anemia Pneumonia Abnormal Pap Urinary Tract Infection Bowel Disorder HTN High Cholesterol

Medical Illnesses I've had are _____

Surgeries I've had are _____

Serious Injuries I've had are _____

Habits

My alcohol intake averages _____ per _____. Tobacco products I use _____ I quit _____ years ago.

I exercise _____ Typical Breakfast _____ Snack _____

Coffee/Tea _____ cups/day Pop _____ cans/day Typical Lunch _____

Water _____ cups/day Typical Dinner _____

My hobbies and interests include _____

Social

I've been married _____ time(s), most recently for _____ years. I have _____ children whose ages are: _____

Educational level _____ I use _____ seatbelts _____ sunscreen _____ Fire Alarm

My job is _____ Physical/Emotional Abuse _____

I have the following health restrictions based on my religious beliefs: _____

My last tetanus shot was: _____

Instructions for the rest of this form:

Mark (+) with person's age or a check mark. These are the diseases we know are found in families. (Please mark only the positives.)

Family History	Mother's Side			Father's Side			Your Siblings				Comments
	GrMother	GrFather	Mother	GrMother	GrFather	Father	Sister	Sister	Brother	Brother	
Heart Attack (age)											
Stroke (age)											
Blood Clots/Bleeding Disorder											
High Blood Pressure											
Diabetes											
High Cholesterol											
Glaucoma/Eye Problems											
Lung Problems											
Kidney Problems											
Arthritis (type)											
Mental (type)											
Other											
Cancers Breast											
Colon											
Prostate											
Uterine											
Other (type)											

Are your parents living? _____ Healthy? _____ If either or both are deceased, please note age(s) at death and causes below:

FOR PROVIDER USE ONLY

Reviewed by & Date	Comments	Reviewed by & Date	Comments

NAME _____ DOB _____ ID# _____

Instructions: Enter today's date at the top of the *left-most unused* column. Check the boxes below that date for any areas of the left column that have changed significantly since your last physical. *Please sign at the bottom.*

Enter Today's Date Here →				
Constitutional	<input type="checkbox"/> Wt Gain <input type="checkbox"/> Wt Loss <input type="checkbox"/> Fatigue	<input type="checkbox"/> Wt Gain <input type="checkbox"/> Wt Loss <input type="checkbox"/> Fatigue	<input type="checkbox"/> Wt Gain <input type="checkbox"/> Wt Loss <input type="checkbox"/> Fatigue	<input type="checkbox"/> Wt Gain <input type="checkbox"/> Wt Loss <input type="checkbox"/> Fatigue
	Amount How long?	Amount How long?	Amount How long?	Amount How long?
	<input type="checkbox"/> Weakness <input type="checkbox"/> Night sweats	<input type="checkbox"/> Weakness <input type="checkbox"/> Night sweats	<input type="checkbox"/> Weakness <input type="checkbox"/> Night sweats	<input type="checkbox"/> Weakness <input type="checkbox"/> Night sweats
Eyes	Last exam <input type="checkbox"/> Change of vision	Last exam <input type="checkbox"/> Change of vision	Last exam <input type="checkbox"/> Change of vision	Last exam <input type="checkbox"/> Change of vision
Ears, Nose, Mouth, Throat	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Difficulty swallowing
	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Hearing loss	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Hearing loss	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Hearing loss	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Hearing loss
Cardiovascular	<input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure	<input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure	<input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure	<input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure
	<input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Swollen legs	<input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Swollen legs	<input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Swollen legs	<input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Swollen legs
Respiratory	<input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing up blood
	<input type="checkbox"/> Cough			
Gastrointestinal	<input type="checkbox"/> Bloody or black stools	<input type="checkbox"/> Bloody or black stools	<input type="checkbox"/> Bloody or black stools	<input type="checkbox"/> Bloody or black stools
	<input type="checkbox"/> Heartburn <input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Heartburn <input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Heartburn <input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Heartburn <input type="checkbox"/> Change in bowel habits
Genitourinary Age 1 st Period:	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty urinating
	<input type="checkbox"/> Vaginal problems <input type="checkbox"/> Sexual problems	<input type="checkbox"/> Vaginal problems <input type="checkbox"/> Sexual problems	<input type="checkbox"/> Vaginal problems <input type="checkbox"/> Sexual problems	<input type="checkbox"/> Vaginal problems <input type="checkbox"/> Sexual problems
	<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Menstrual problems
	Last pap smear:	Last pap smear:	Last pap smear:	Last pap smear:
Musculoskeletal	<input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle weakness
Skin	<input type="checkbox"/> Changing bumps or moles	<input type="checkbox"/> Changing bumps or moles	<input type="checkbox"/> Changing bumps or moles	<input type="checkbox"/> Changing bumps or moles
Breasts	<input type="checkbox"/> I check, there are no changing lumps	<input type="checkbox"/> I check, there are no changing lumps	<input type="checkbox"/> I check, there are no changing lumps	<input type="checkbox"/> I check, there are no changing lumps
	<input type="checkbox"/> I have a lump(s) that is different	<input type="checkbox"/> I have a lump(s) that is different	<input type="checkbox"/> I have a lump(s) that is different	<input type="checkbox"/> I have a lump(s) that is different
	Last Mammogram:	Last Mammogram:	Last Mammogram:	Last Mammogram:
Neurological	<input type="checkbox"/> Headache <input type="checkbox"/> Memory loss	<input type="checkbox"/> Headache <input type="checkbox"/> Memory loss	<input type="checkbox"/> Headache <input type="checkbox"/> Memory loss	<input type="checkbox"/> Headache <input type="checkbox"/> Memory loss
Psychiatric	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety
	<input type="checkbox"/> Sleep Disorder	<input type="checkbox"/> Sleep Disorder	<input type="checkbox"/> Sleep Disorder	<input type="checkbox"/> Sleep Disorder
Endocrine	<input type="checkbox"/> I take hormones Name:	<input type="checkbox"/> I take hormones Name:	<input type="checkbox"/> I take hormones Name:	<input type="checkbox"/> I take hormones Name:
	<input type="checkbox"/> Excessive thirst, appetite, urination	<input type="checkbox"/> Excessive thirst, appetite, urination	<input type="checkbox"/> Excessive thirst, appetite, urination	<input type="checkbox"/> Excessive thirst, appetite, urination
Contraception	<input type="checkbox"/> Birth Control	<input type="checkbox"/> Birth Control	<input type="checkbox"/> Birth Control	<input type="checkbox"/> Birth Control
Blood / Lymphatic	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Bleeding Tendency
	Taking medication for:	Taking medication for:	Taking medication for:	Taking medication for:
Allergy / Immune	<input type="checkbox"/> Rash <input type="checkbox"/> Hives	<input type="checkbox"/> Rash <input type="checkbox"/> Hives	<input type="checkbox"/> Rash <input type="checkbox"/> Hives	<input type="checkbox"/> Rash <input type="checkbox"/> Hives
	<input type="checkbox"/> AIDS Risk Factor	<input type="checkbox"/> AIDS Risk Factor	<input type="checkbox"/> AIDS Risk Factor	<input type="checkbox"/> AIDS Risk Factor
	Last Tetanus:	Last Tetanus:	Last Tetanus:	Last Tetanus:
Provider Initial & Date				

Patient's Signature _____