PATIENT HISTORY FORM

Name:_____ **Date:** _____

Main Reason for Today's Visit _____

Date of Last Complete Medical Exam: _____

Date of Last Eye Exam:_____ **Date of Last Dental Exam:** _____

Overall State of Health: _____

Current Medications (Include Non-Prescription):

Name of Med	Strength	Times per day

Allergies (medications): _____

_____

Medical History

Surgeries (Date & Type):

Hospitalizations (Date & Reason):

Serious Illnesses/Injuries (date & description):

Diagnostic tests/procedures (date & type):

Other:

Men's Health

Do you Perform Self-Testicular Exams? Yes / No
Problems Starting or Urinating Completely emptying your bladder? Yes / No
Birth Control Method: _____
Any other Concerns?

Women's Health

Date of Last Menstrual Period: _____
Usual # of Days on Menses: _____
Usual # of Days in Cycle: _____ Age at First Menses:____
Do you have PMS? Yes / No
Number of Pregnancies:_____ Number of Deliveries: _____
Any Abortions or Miscarriages: _____ Number of Living Children: _____
Birth Control Method:_____ Seeking Pregnancy? Yes / No
Date of Last Mammogram:_____ Results: _____
Date of Last Pap Smear:_____ Results: _____
Do you Regularly Do Self-Breast Exams? Yes / No
Any other concerns?

Social History

Occupation: **Education Level:**

Living Situation:

Social Support: **Sexual Preference:**

Recreation/Interests:

Religious/Spiritual:

Tobacco Use: **Caffeine Intake:**

Alcohol Use: **Street Drug Use:**

Exercise: **Sleep Pattern:**

Stress Management:

Eating Habits (circle all that apply): high fat / high salt / high fiber / daily fruits / daily vegetables / variety of foods / at least 4 glasses of water daily

Diet/Food Supplements (circle all that apply): Multiple vitamin / Calcium / Vitamin D / Vitamin C / Vitamin B Complex / Fluoride / Protein / Minerals Supplements _____
Other supplements (list):

Family Illness History

Please circle all that apply and list family member affected:

Condition:	Family Member:
Heart Disease	
High Blood Pressure	
Stroke	
Diabetes	
Thyroid Disease	
Cancer (breast, uterus, ovaries)	
Cancer (other)	
Glaucoma	
Osteoporosis	
Birth Defects	
Bleeding Disorders	
Sickle Cell Anemia	
Mental Retardation	
Mental Health Problems	
Alcoholism/Drug Abuse	
Seizures/Epilepsy	
Other	

Immediate Family Health History

Member	Living/Dead	Age	Illness/Cause of Death
Father			
Mother			
Sister/Brother			
Sister/Brother			
Sister/Brother			
Sister/Brother			
Son/Daughter			
Son/Daughter			
Son/Daughter			
Son/Daughter			
Spouse			

Immunization & TB Test Status

List date last given:

Tetanus Booster (Td or Tdap) Shingles

COVID Pneumonia

Hepatitis B Other

Review of Systems

Please circle any of the following conditions or symptoms you have had Recently:

General:
Weight Changes Excessive Thirst
Fever or Chills intolerance to heat
Weakness Fatigue
Insomnia Loss of Appetite

Skin:
Rash/Sores/Lumps Itching
Change in Mole Change Mole Color

Eyes:
Blurred Vision Halo Around Lights
Wear Glasses or Contacts Eye pain

Ears:
Ringing Hearing Loss
Drainage from the Ears

Mouth/Throat:
Tooth Ache Difficulty Swallowing Sinus Pain or Pressure Dentures
Problems Difficulty Chewing Hay Fever

Head:
Headache Loss of Consciousness
Head Injury Dizziness

Neck:
Swelling Pain
Lumps Decreased Range of Motion

Pulmonological
Wheezing Shortness of breath
Cough Production of Sputum
Blood in Sputum Tuberculosis

Cardiological:
Chest Pain Arm or Jaw Pain
Swelling Irregular Heart Beat
Dizziness Heart Valve Problem

Breasts
Lumps Nipple Discharge
Redness or Hot to Breast Pain

Gastrointestinal:
Nausea or Vomiting Diarrhea/Loose Stools
Heartburn Hepatitis
Bleeding Hemorrhoids Gall Bladder Problems
Problem with B/M Constipation

Genitourinary:
Frequent Urination Nighttime Urination
Painful Urination Discolored Urine
Hesitancy Discharge
Stress Incontinence Sores
Painful Sex Problem with

Muscular Skeletal:
Joint Pain Stiffness
Varicose Veins Gout
Backache Muscle Pain
Blood Clots Pain with Exercise

Neurological:
Seizure/Epilepsy Blackouts
Paralysis Weakness
Tremors Memory Issues

Endocrine:
Thyroid Disease Diabetes
Intolerance to Heat or Cold

Hematologic:
Bleeding Disorder Bruise Easily
Blood Transfusion Anemia

Psychiatric:
Depression Anxiety
Bipolar Personality Disorder
Anger issues Multiple Personality
Schizophrenia

How are things going at home?

How are things going at work/school?

Do you feel safe in your home?

Patient Signature: _____

This Section Office Use Only:

Form Reviewed By_____Review Date: _____

Advanced Directive Reviewed_____ Review Date: _____

Reviewer's Comments: