PATIENT HISTORY FORM

Name:____**Birth Date:**_________________**Today's Date:** ________________

Pharmacy: ____

Medication & Dose	How Often?

Immunizations?	Date Received?
Shingles	
Pneumonia	
Hepatitis	
Tetanus	
Influenza	
COVID	
Other	

Vitamins/Supplements: *(please list)* ____

Any prescription drug allergies? None ☐ **Yes** *(please list)* ____

HEALTH HISTORY *No Change?* ☐

Do you exercise regularly? ☐ Yes ☐ No How often?______ What do you do for stress management? ______________________________

Do you eat a balanced diet? ☐ Yes ☐ No How many hours do you sleep at night?_______ Do you feel rested when you wake? ☐ Yes ☐ No

How do you identify? ☐ Male ☐ Female ☐ non-binary, what is your sexual preference? ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Do you regularly perform self-exams? ☐ Yes ☐ No Birth Control Method?____________________ Erectile dysfunction? ☐ Yes ☐ No

Female: Last period?_________ Usual number menstruating days?______Seeking pregnancy? ☐Yes ☐No, Number of Pregnancies?___________

Number of live births?_______Date of last pap smear?__________ Results? ☐ Normal ☐ Abnormal Last Mammogram? ________________

Last dental exam?__________Last colonoscopy?___________Last bone density? ___________ Last eye exam? ___________

SURGICAL/HOSPITAL HISTORY *No Change?* ☐

Have you had any surgeries? *(please list and provide dates)*

____
____
____
____

Hospitalizations? *(Please list and provide dates)*

____
____
____
____

SOCIAL HISTORY *No Change?* ☐

Are you employed? ☐ Yes ☐ No, Occupation?___________________ Do you have a good social support network? ☐ Yes ☐ No

How are things going at home, school and/or work?____________________________________ Do you feel safe at home? ☐ Yes ☐ No

Tobacco? No ☐ Former ☐ Ye s☐ How much?_____ For how many years?______ Are you ready to quit? Yes ☐ No ☐

Do you consume caffeine? ☐ Yes ☐ No How much?______________ Do you drink alcohol? Yes ☐ No ☐ How much? __________________

Do you use street drugs? ☐ Yes ☐ No How often?______ Do you use opioids or THC? Yes ☐ No ☐ How often? __________________________

FAMILY HISTORY *No Change?* ☐

Mother: ☐ Living ☐ Deceased? If Deceased, Age at Death?________Cause of Death? ____

Father: ☐ Living ☐ Deceased? If Deceased, Age at Death? ___________Cause of Death? ____

Sibling: ☐ Brother ☐ Sister, ☐ Living ☐ Deceased? If Deceased, Age at Death?____________Cause of Death? ________________________

Sibling: ☐ Brother ☐ Sister, ☐ Living ☐ Deceased? If Deceased, Age at Death?___________Cause of Death? __________________________

Sibling: ☐ Brother ☐ Sister, ☐ Living ☐ Deceased? If Deceased, Age at Death?___________Cause of Death? __________________________

Child: ☐ Son ☐ Daughter ☐ Living ☐ Deceased? If Deceased, Age at Death?________Cause of Death _______________________________

Child: ☐ Son ☐ Daughter ☐ Living ☐ Deceased? If Deceased, Age at Death?________Cause of Death __________________________________

Child: ☐ Son ☐ Daughter ☐ Living ☐ Deceased? If Deceased, Age at Death?________Cause of Death ________________________________

Child: ☐ Son ☐ Daughter ☐ Living ☐ Deceased? If Deceased, Age at Death? ____________Cause of Death? ____________________________

Heart disease or attack? ☐ Yes ☐ No, Who? _______________________Who? _________________________Who?________________________

Diabetes? ☐ Yes ☐ No, Who?____________________________Who?__________________________Who? _____________________________

Cancer? ☐ Yes ☐ No, What type? ___________________ Who?______________________Who?___________________Who? __________________

Stroke? ☐ Yes ☐ No, Who?____________________________Who?_________________________Who?__________________________

Osteoporosis? ☐ Yes ☐ No, Who?______________________________Who?__________________________Who?_____________________

Bleeding disorder? ☐Yes ☐No, Who?____________________________Who?__________________________Who?___________________

Mental health problems? ☐ Yes ☐ No, Who?____________________Who?________________________________Who? _________________

Seizures/Epilepsy? ☐ Yes ☐ No, Who?____________________________Who?_____________________________Who? _________________

Other? ____

REVIEW OF SYSTEMS

Constitutional
☐Fever
☐Night Sweats
☐Chills
☐Cold Intolerance
☐Fatigue
☐Daytime Sleepiness
☐Weight Loss/Gain
☐Excessive
☐Thirst/Appetite
☐Anorexia

Eyes
☐Changes to Vision
☐Eye Redness/Pain
☐Watering Eyes or Drainage

Ears
☐Changes to Hearing
☐Ear Pain/Ear Ache
☐Ear Drainage
☐Ringing In the Ears

Nose
☐Nasal Congestion
☐Nasal Discharge
☐Frequent Bloody Nose
☐Snoring

Mouth
☐Mouth Sores
☐Difficulty Swallowing
☐Bleeding Gums
☐Dental Problems
☐Change in Voice

Neck
☐Neck Pain
☐Neck Stiffness
☐Neck Lumps
☐Neck Swelling

Respiratory
☐Shortness of Breath
☐Cough
☐Productive
☐Wheezing

Cardiovascular
☐Chest Pain
☐Palpitations
☐Shortness of Breath
☐Lower Extremity Edema
☐Varicose Veins

Breast
☐Breast Lump
☐Breast Pain
☐Nipple Discharge

Gastrointestinal
☐Abdominal Pain
☐Rectal Pain
☐Nausea/Vomiting
☐Gas/Bloating
☐Constipation
☐Diarrhea
☐Fecal Incontinence
☐Changes in Stool

Urinary
☐Painful Urination
☐Blood in the Urine
☐Urine Hesitancy
☐Difficulty Urinating
☐Increased Frequency
☐Decreased Frequency
☐Urgency Symptoms
☐Urinary Incontinence

Reproductive
☐Change in Libido
☐Pain with Intercourse
☐Erectile Problems
☐Difficulty Orgasming
☐Excessive Bleeding
☐Irregular Period
☐Postmenopausal
☐Menopause Symptom
☐Vaginal Discharge

Dermatologic
☐Change in Hair
☐Hair Loss
☐Change in Nail
☐Changes to Skin
☐Dry Skin
☐Itching/Hives/Rash
☐Bruising
☐New Mole(s)
☐Skin Sores/Lumps

Musculosketal
☐Muscle Pain/Cramping
☐Back Pain
☐Tender Points
☐Muscle Cramps
☐Limb Paralysis
☐Difficulty Walking

Neurological
☐Headache
☐Vertigo
☐Lightheadedness
☐Fainting/Blackouts
☐Numbness/Tingling
☐Tremor
☐Lack of Coordination
☐Difficulty Speaking
☐Memory Loss
☐Difficulty Concentrating

Psychiatric
☐Change in Mood
☐Depression
☐Anxiety/Nervousness
☐Sleep Disturbance
☐Suicidal Ideation
☐Hopelessness
☐Worthlessness
☐Delusions
☐Hallucinations

Hematologic
☐Easy Brusing
☐Bleeding Issues
☐Lymph Enlargement
☐Lymph Tenderness

Is there anything else that you would like to address today?

____
____
____

PATIENT SIGNATURE: ______________________________Reviewed By (staff):_____________________

Reviewer Comments:

POLST Reviewed ☐ Yes ☐ No
Advanced Directive Reviewed ☐ Yes ☐ No
Durable Power of Attorney Reviewed? ☐ Yes ☐ No