PATIENT HISTORY FORM

Date: ____________________

Name: ______________________________ DOB ____________ Gender F M

Marrital Status S M W D Occupation ______________________ # of Children __________

Medications

name & dosage include over the counter drugs

Allergies: Reaction:

Medical History

System	Yes	No	System	Yes	No	System	Yes	No
High Blood Pressure			Hoarseness			Kidney Stones		
Chest Pain			Pneumonia			Bleeding Disorder		
Heart Attack			Shortness of Breath			Arthritis		
Irregular Heartbeat			Tuberculosis			Back Pain		
Rheumatic Fever			Diarrhea			Muscle Disease		
High Cholesterol			Constipation			Glaucoma		
Diabetes			Weight Loss			Cataracts		
Thyroid Disorder			Hepatitis			Alcoholism/Drug use		
Stroke			Heartburn			Anxiety		
Seizures			Liver Disease			Depression		
Migraines			Rectal Bleeding			Sexual Dysfunction		
Asthma			Blood in Urine			AIDS/HIV		
Chronic Cough			Cancer: type					

Regular Exercise days/week ______________________________

Smoking History: ❒ Never ❒ Current ❒ Former kind/how long ______________________________

Number Alcoholic Beverages Consumed: week __________ month __________

Use of recreational / Illicit drugs: ❒ Never ❒ Current ❒ Former kind/how long ______________________________

SURGERIES / HOSPITALIZATIONS

Surgery	Date	Surgery	Date

PREVENTIVE HEALTH

Regular Seatbelt Use: Yes No

	Date	Place of Exam
Last Eye Exam		
Last Colonoscopy		
Last Mammogram		

FAMILY HISTORY

Please indicate if your parent, grandparent, brother, sister and/or children had had any of the following:

❒ Heart Disease ❒ Diabetes ❒ Bleeding Disorder ❒ Thyroid Disorder ❒ Asthma ❒ Thyroid Disorder

❒ Cancer ______________________________

______________________________ ______________________________ ______________

Person completing this form Reviewed by Provider Date