

## PATIENT HISTORY FORM

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

☐ New Patient ☐ Consult ☐ Self-Referred Family Doctor: \_\_\_\_\_

Referred By: \_\_\_\_\_

**CHIEF COMPLAINT:** \_\_\_\_\_

HPI: \_\_\_\_\_

### MEDICAL HISTORY

(Please check any of the following if you have had any problems)

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Ulcers/Bleeding	<input type="checkbox"/> Stomach	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Blood Transfusions

Other \_\_\_\_\_

### FAMILY HISTORY

Any family history of the following problems? (Mother, Father, Brother, Sister)

☐ Stroke ☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease

☐ Cancer: What type of cancer? \_\_\_\_\_

Who? \_\_\_\_\_

### PAST SURGICAL HISTORY

☐ Hernia ☐ Appendix ☐ Gallbladder ☐ Colon ☐ Cancer

Other \_\_\_\_\_

### SOCIAL HISTORY

Marital Status: ☐ married ☐ single ☐ divorced ☐ widowed

What is (was) your main occupation: \_\_\_\_\_

Alcohol? yes no How many drinks a week? \_\_\_\_\_

Use Tobacco Products? ☐ yes or ☐ no

**ALLERGIES** ☐ None ☐ Sulfa ☐ Penicillin ☐ Tape ☐ Iodine

Other \_\_\_\_\_

**MEDICATIONS** ☐ None

\_\_\_\_\_  
\_\_\_\_\_

## PATIENT HISTORY FORM

NON-PRESCRIPTION MEDS/HERBAL SUPPLEMENTS: ☐ None

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### REVIEW OF SYSTEMS

#### HEENT

- ☐ Any eye disease, sight impairment
- ☐ Glasses
- ☐ Ear disease, hearing impairment
- ☐ Hearing aid R or L

#### CNS

- ☐ Loss of consciousness
- ☐ Convulsions
- ☐ Paralysis
- ☐ Frequent headaches

#### CARDIOPULMONARY

- ☐ Chronic or frequent cough
- ☐ Chest pain or angina pectoris
- ☐ Spitting up blood
- ☐ Heart Attack
- ☐ Shortness of Breath
- ☐ Palpitation or fluttering heart
- ☐ Swelling of feet, ankles
- ☐ Varicose veins

#### CONSTITUTIONAL

- ☐ Fever
- ☐ Nausea
- ☐ Weight Changes

#### GENITOURINARY

- ☐ Prostate enlargement
- ☐ Kidney disease/stones
- ☐ Bladder disease
- ☐ Difficulty urinating

#### NEUROMUSCULAR

- ☐ Stroke
- ☐ Weakness in arms or legs
- ☐ Muscle spasms or cramps

#### ENDOCRINE

- ☐ Enlarged glands
- ☐ Enlarged Thyroid or goiter
- ☐ Skin disease
- ☐ Breast Problems

#### GASTROINTESTINAL

- ☐ Stomach trouble or ulcers
- ☐ Indigestions
- ☐ Liver or gallbladder disease
- ☐ Colitis or other bowel disease
- ☐ Hemorrhoids or rectal bleeding

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PRINT NAME

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SIGNATURE

#### NOTE:

This is a confidential record of your medical history and will be kept in this office.. Information contained herein will not be released to any person except with your authorization.