

Patient History

Patient Name _____

Birthdate _____ Age _____

Date _____

Previous Hospitalizations & Surgery

Date/Problem/Hospital _____

Date/Problem/Hospital _____

Date/Problem/Hospital _____

Date/Problem/Hospital _____

Pregnancies# _____ Deliveries # _____ Miscarriages # _____

Transfusions/Dates _____

Infectious Diseases (Circle All that Apply)

Chicken Pox, Diphtheria, Croup, Mumps, Whooping Cough, Rheumatic Fever, German Measles, Scarlet Fever, Malaria, Tuberculosis or positive skin test for Tb, Typhoid Fever, AIDS, Hepatitis (A), (B) or (C)

Major Illnesses

High Blood Pressure, Heart Trouble, Cholesterol, Kidney or Liver Disease, Lung disease, (Emphysema/COPD), Cancer, Stroke, Bleeding Disorders, Arthritis (rheumatoid vs. Osteoarthritis), Gout, Thyroid Problems, Diabetes

Allergies _____

Current Medications: (list name and dosage)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Relation	Age if Living	Age when deceased	Medical Problems
Father			
Mother			
Brothers			
Sisters			
Children			

Social History

Marital Status M S W D Religion _____
Occupation _____ Hobbies _____
Military Service _____ World Travel Dates _____
Alcohol ___ times per week Tobacco (cigarettes/cigar/pipe,chew/snuff) ___ number per day
Coffee/Tea/Caffeinated Pop ___ Number per day Smoker in household Y N

Systemic Review (Are you troubled with) Circle all that apply during the past 1-3 months:

- General Fatigue, Weakness, Problems with Sleeping, Chills, Fever, Night Sweats, How many Pounds weight change in last 6 months ___ up/down?
Are you in good general health? Y N
- Neuro Dizziness, Headache, Convulsions, Fainting, Nervousness, Tremors, difficulty with Walking, Paralysis, Numbness or tingling in Extremities, Loss of Muscle Control, Depression, Anxiety
- Eyes Eye Pain, Blurring of Vision, Flashes/Spots, Itching, Redness, Unable to tolerate strong light, Dry Eyes, Blindness, Do you wear Glasses ___ Contacts _____
- Ears Discharge, Pain, Buzzing, Ringing, Poor Hearing, Need or use hearing aid
- Nose Discharge, Nosebleeds, Sinus Problems, Difficulty Breathing through Nose, Allergies
- Mouth Bleeding of gums, Lip sores, Tooth pain, Burning of the Tongue, Dry Mouth, Bad Breath, Do you wear Dentures ___ Partial Plates _____
- Throat Hoarseness, difficulty with Swallowing (Choking/Coughing), Abnormal Speech, Chronic Tonsillitis
- Neck Pain, Stiffness, Abnormal Lymph Nodes or Swelling, Thyroid Problems
- Lungs Asthma, Bronchitis, Wheezing, Chronic Cough, Blood or Sputum color _____, History of Lung Disease or tuberculosis, shortness of Breath either at Rest or Exertion, Loud Snoring with lapses in respiration
- Heart History of Heart Disease, Chest pain, Palpitations, High Blood Pressure, Cold Feet or Cramps in Legs when walking, Family History of Heart Disease, Need to Sleep on More than One Pillow, Wake up at Night short of Breath, Swelling of Ankles
- Intestinal Poor Appetite, Foods you can't eat _____
Frequent Vomiting, Vomiting Blood, History of Ulcers or Colitis, Excessive Belching or Gas, Constipation, Diarrhea, Change in Bowel Habits, Bloody or Black Stools, History of Hepatitis or Jaundice, Gallbladder Disease, Hemorrhoids, Personal or Family History of Colon Cancer
- Urinary Prostate Problems, Incontinence, Burning with Urination, Blood in Urine, Hernia, How often do you get up at night to urinate ___ times, Last PSA _____, Normal? Y N
Males – Change in Urinary Stream, Change in Testicle Size or Shape, Problem with Sex Drive
Females – Last Menstrual Period _____, Last Mammogram _____, Any Breast Discharge Y N, Lumps or Bleeding, Pain with Intercourse, Sex Drive Changes, On Oral Contraceptives Y N, Hormone Replacement Therapy Y N
- Extremities Ankle Swelling, Varicose Veins, Arthritis Pain, Stiff or Swollen Joints, Previous Fractures
- Skin Moles that have changed in Color or Size, Hives, Rash, Itching, Eczema, Psoriasis
- Other Excessive Thirst or Urination, Muscle Cramping, Palpitations, Unusual Intolerance of Heat or Cold, Swelling in Neck, Voice Changes, Tender or Swollen Lymph Glands, Easy Bruising, Bleeding disorders, Abnormal Hair Loss or Growth

Most Recent Immunization Dates

Tetanus _____ Influenza _____ Pneumovax _____
Childhood Series Up to Date Y N Hepatitis Series Completed Y N Date _____