Patient History

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Sex:___ Marital Status: S M W D

Referring Physician:_____ Primary Physician_____

Other Physicians:_____
_____

Reason for your visit today:_____

Past Medical History

Do you have a history of the following?

	Yes	No		Yes	No
Arthritis	___	___	High blood pressure	___	___
Asthma	___	___	High cholesterol	___	___
Anxiety	___	___	Kidney disease	___	___
Blood disease	___	___	Pneumonia	___	___
Cancer	___	___	Rheumatic Fever	___	___
C.H.F.	___	___	Seizures	___	___
Cystic Fibrosis	___	___	Thyroid disease	___	___
Depression	___	___	Tuberculosis	___	___
Diabetes	___	___	Ulcers	___	___
Emphysema	___	___	UTI's	___	___
Epilepsy	___	___	Valley Fever	___	___
GERD/Reflux	___	___	Stroke	___	___
Hepatitis	___	___	Aneurysm	___	___
Heart Disease	___	___	Prostate Problems	___	___

Medications with dosage (including over-the-counter and herbal supplements):

_____
_____
_____
_____
_____
_____

Medication Allergies_____

Surgeries (give dates): _____
_____
_____

Other hospitalizations: _____
_____

Patient Name: _____

Family Medical History: Does anyone in your family have any of the following?

	Yes	No		Yes	No
Heart Disease	___	___	Heart Attack	___	___
High Blood Pressure	___	___	Diabetes	___	___
Stroke	___	___	Aneurysm	___	___
Cancer	___	___	Lung Disease	___	___
Tuberculosis	___	___	Cystic Fibrosis	___	___

Mother: Alive___ Deceased___ Cause_____
Father: Alive___ Deceased___ Cause_____
Siblings: Number___Alive___ Deceased___ Causes_____
Your Children Number___Alive___ Deceased___Causes_____

Social History:
Previous and present occupations:_____
Regular exercise? What do you do and how often?_____
_____
Drink alcohol? How much and how often?_____
Illegal drugs?_____
Were you or are you a smoker?_____
How many packs per day?_____
How may years in total did you smoke?_____
When did you stop smoking?_____

Review of Systems: Have you experienced any of the following in the past year?

	Yes	No	
Change weight	___	___	_____
Change in appetite/food	___	___	_____
Hoarseness	___	___	_____
Difficulty swallowing	___	___	_____
Chronic cough	___	___	_____
Sputum with cough (color)	___	___	_____
Coughing of blood	___	___	_____
Shortness of breath	___	___	_____
Chest pain	___	___	_____
Blood in urine	___	___	_____
Kidney problems	___	___	_____
Black tarry stools	___	___	_____
Rectal bleeding	___	___	_____
Recurrent infections	___	___	_____
Fatigue	___	___	_____
Anemia	___	___	_____