Patient History Form

(continued on back)

Date: _____

Patient Name: _____ **DOB:** _____ / _____ / _____

Describe your main problem: _____

When does this problem occur? _____

What other things happen with this problem? _____

Where is your problem located? _____

How severe is your problem? _____

How long have you had this problem? _____

List previous hospitalizations / surgeries / serious injuries:	**When?**	**Do you have a…**
_____	_____	pacemaker? Y / N
_____	_____	
_____	_____	defibrillator? Y / N
_____	_____	
_____	_____	

Patient Social History

Marital status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Use of alcohol: Never ___ Rarely ___ Moderate ___ Daily ___

Use of tobacco: Never ___ Former___ Some days___ Everyday___

Use of drugs: Never ___ Type / Frequency _____

Height: _____

Weight: _____

Personal Medical History

Have **you** ever had any of the following?

Diabetes	No	Yes
Kidney failure	No	Yes
Cancer	No	Yes(type)_____
Stroke	No	Yes
Heart failure	No	Yes
Arthritis / gout	No	Yes
Hypertension	No	Yes
Bleeding tendency	No	Yes
Acute infections	No	Yes
Venereal diseases	No	Yes
Hereditary defects	No	Yes

Family Medical History

	Disease	**Age**
Father -	_____	_____
Mother -	_____	_____
Siblings -	_____	_____
	_____	_____
	_____	_____
Spouse -	_____	_____
Children -	_____	_____
	_____	_____
	_____	_____

List any medications you are currently taking:

Medication	Dosage	How often is it taken?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any drug allergies and your reaction:

Drug	Reaction
_____	_____
_____	_____
_____	_____

Are you currently taking blood thinners (coumadin, warfarin, Plavix, etc.)?

No / Yes

If yes, please list here:

_____

_____

Have you had any of the following **during the past three months?**

Constitutional:		
Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

Eyes:		
Eye disease or injury	No	Yes
Wear glasses / contacts	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

ENT:		
Hearing loss	No	Yes
Ringing in the ears	No	Yes
Earaches or drainage	No	Yes
Sinus problems	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

Cardiovascular:		
Heart trouble	No	Yes
Chest pains	No	Yes
Sudden heartbeat changes	No	Yes
Swelling of feet, ankles, or hands	No	Yes

Respiratory:		
Frequent coughing	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

Urological:		
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change of force of strain urinating	No	Yes
Incontinence if dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Testicle pain (Male)	No	Yes
Pain with periods (Female)	No	Yes
Irregular periods (Female)	No	Yes
Vaginal discharge (Female)	No	Yes

Musculoskeletal:		
Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

Skin:		
Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

Neurological:		
Frequent, recurring headaches	No	Yes
Lightheaded or dizziness	No	Yes
Convulsions or seizures	No	Yes
Numbness, tingling sensation	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

Psychiatric:		
Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Sleep problems	No	Yes

Endocrine:		
Grandular, hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes
Change in hat or glove size	No	Yes

Hematology / lymphatic:		
Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

Female:

# of pregnancies____ Date of last pap smear_____

# of miscarriages____ Findings: Normal____ Abnormal____

Patient Signature: _____ Physician Signature: _____