

PATIENT HISTORY FORM

Medical History Circle all items that apply to you:

High Blood Pressure	High Cholesterol	Back Problems	Hearing/Vision Pblms
Heart Disease/Murmur	Cancer	Thyroid Disorder	Lung Disease
Stroke	Neurological Problems	Diabetes	Skin Disorder
Arthritis	Kidney Disorder	Stomach/Digestive Disorder	HIV

Previous Hospitalizations/Surgeries/Serious Injuries and Dates: _____

Additional Information: _____

Social History

Marital Status: Single Married Separated Divorced Widowed
Use of Alcohol: Never Rarely Moderate Daily Quit
Use of Tobacco: Never Quit Currently chew/ smoke _____ packs/day
Use of Drugs: Never Type/Frequency _____
Sexual Preference: Heterosexual Homosexual Bisexual SEX: M F
Occupation: _____

Family History

Mother: Alive/Deceased Medical Problems: _____
Father: Alive/Deceased Medical Problems: _____
Siblings: Alive/Deceased Medical Problems: _____

Current Medications: _____

SYSTEM REVIEW Circle all items in each category that you have presently or have had in the past:

General

Recent weight change
Fever
Fatigue
Headache

Gastrointestinal

Loss of appetite
Change in bowel movements
Nausea/Vomiting
Frequent diarrhea
Constipation/painful BM
Rectal bleeding/ blood in stool
Abdominal pain or heartburn
Peptic ulcer

Endocrine

Glandular/hormone problem
Thyroid
Diabetes
Excessive thirst/urination
Heat or cold intolerance
Dry skin
Change in hat or glove size

Eyes

Eye disease or injury
Glasses/Contact lenses
Blurred or double vision
Glaucoma

Integumentary (skin/breast)

Rash or itching
Change in skin color
Change in hair or nails
Varicose veins
Breast pain
Breast lump
Breast discharge
History breast CA
Last Mammogram _____
History of cyst

Genitourinary

Frequent urination
Burning/painful urination
Blood in urine
Force/strain in urination
Incontinence/dribbling
Kidney stones
Sexual difficulty
Male - testicular pain
Female . pain with periods
Irregular periods
Vaginal discharge
of pregnancies _____
of miscarriages _____
Date last Pap _____
Date of LMP _____

Hematological/Lymphatic

Slow to heal after cuts
Bleeding or bruising
Anemia
Phlebitis
Transfusion
Enlarged glands
Hepatitis A B C /HIV

Musculoskeletal

Joint pain
Joint stiffness
Joint swelling
Joint weakness
Muscle weakness
Back pain
Cold extremities
Difficulty in walking
Muscle pain/cramps

Ears/Nose/Throat/Mouth

Hearing loss or ringing
Earaches or drainage
Chronic sinus problems
Nose bleeds
Mouth sores
Bleeding gums
Sore throat or voice change

Neurological

Frequent/recurring headaches
Light headed/dizziness
Convulsions/seizures
Numbness/tingling sensation
Tremors
Paralysis
Head Injury

Respiratory

Chronic or frequent cough
Spitting up blood
Shortness of breath
Asthma or wheezing

Cardiovascular

Abnormalities
Chest Pain
Palpitations
Swelling of feet, ankles or hands

PATIENT NAME _____ DATE _____