

PATIENT HISTORY FORM

LAST NAME _____ FIRST NAME: _____ DOB: _____ DATE _____

Review of Systems (2 pages)

Circle Yes or No.

General Symptoms	NOW	PAST	(Comments)	Genitourinary	NOW	PAST	(Comments)
Weight change	Y N	Y N		Change in stream	Y N	Y N	
Chills	Y N	Y N		Nocturia (getting up at night)	Y N	Y N	
Sleep Disorder	Y N	Y N		Urinary frequency > 8 times/day	Y N	Y N	
Other				Other			
Eyes				Musculoskeletal			
Double vision	Y N	Y N		Bone pain	Y N	Y N	
Glaucoma	Y N	Y N		Muscle pain	Y N	Y N	
Cataracts	Y N	Y N		Joint pain	Y N	Y N	
Other				Other			
Ear/Nose/Throat/Mouth				Skin			
Hearing changes	Y N	Y N		Rash	Y N	Y N	
Sore throat	Y N	Y N		Lumps or bumps	Y N	Y N	
Sinus problem	Y N	Y N		Moles, skin tags	Y N	Y N	
Other				Other			
Cardiovascular				Neurological			
Chest pain	Y N	Y N		Tremors	Y N	Y N	
Irregular heartbeat	Y N	Y N		Dizzy spells	Y N	Y N	
Swelling in ankles	Y N	Y N		Numbness/tingling	Y N	Y N	
Other				Other			
Psychologic				Respiratory			
Are you generally happy?	Y N	Y N		Wheezing	Y N	Y N	
Do you feel depressed?	Y N	Y N		Frequent cough	Y N	Y N	
Do you feel anxious?	Y N	Y N		Shortness of breath	Y N	Y N	
Do you feel safe in your home?	Y N	Y N		Other			
Endocrine				Gastrointestinal			
Excessive thirst	Y N	Y N		Abdominal pain	Y N	Y N	
Too hot/cold	Y N	Y N		Nausea/vomiting	Y N	Y N	
Tired/sluggish	Y N	Y N		Indigestion/heartburn	Y N	Y N	
Other				Other			
Hematologic/Lymphatic				Sexual History			
Swollen glands	Y N	Y N		Change in sex drive?	Y N		
Blood clotting problem	Y N	Y N		Sexual performance satisfactory?	Y N		
Bruising	Y N	Y N		Other (i.e. sexual trauma)			
Other							
Allergic/Immune				Last Exams or Lab tests: Please enter date (mo/yr)			
Hay Fever	Y N	Y N		Dental: _____	Eye: _____		
Drug allergies	Y N	Y N		Pelvic: _____	PAP smear: _____		
Food	Y N	Y N		Mammogram: _____	Cholesterol: _____		
Other				Colonoscopy: _____	Stool Tested: _____		
				Prostate _____	PSA test: _____		

Living Will? Yes No

Advanced Directive? Yes No

Doctor's signature: _____

(Please Complete Other Side)

Medical History

Medical <input type="checkbox"/> None (<i>High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.</i>) _____ _____ _____ _____ _____	Pregnancy History <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">Year</th> <th style="width: 25%;">Sex</th> <th style="width: 50%;">Complications</th> </tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </table>	Year	Sex	Complications	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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Surgical None (*Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc - Please enter year surgery was done if known*)

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

Allergies to medications? None (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

Last Immunizations: FLU ___/___/___ PNEU ___/___/___ Tetanus ___/___/___ Other _____

Current prescription medicines: <input type="checkbox"/> None <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name of drug</th> <th style="width: 15%;">mg dose</th> <th style="width: 15%;"># tablets</th> <th style="width: 15%;"># times per day</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	Name of drug	mg dose	# tablets	# times per day	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	Additional current prescription medicines: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name of drug</th> <th style="width: 15%;">mg dose</th> <th style="width: 15%;"># tablets</th> <th style="width: 15%;"># times per day</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	Name of drug	mg dose	# tablets	# times per day	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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Current Non-Prescription Medicine (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins, anti-acids, herbals.)

Family History

Father: Living - Age: _____ Deceased, Age at Death _____ (Cause) _____

Mother: Living - Age: _____ Deceased, Age at Death _____ (Cause) _____

Siblings: Number Living _____ Number deceased _____ (Cause) _____

List other illnesses in your family (Example - Diabetes, heart disease, colon, breast, or prostate cancer, arthritis, depression etc)

(Family Member)	(Illness)	(Family Member)	(Illness)
_____ = _____	_____ = _____	_____ = _____	_____ = _____

Social History

Caffeine Yes No If yes, how much? _____

Smoke? Yes No If yes, how much? _____ # of packs/day _____ # of years When did you stop smoking? _____

Alcohol? Yes No If yes, how much? _____

OCCUPATION. _____ Retired Significant prior industrial or agricultural exposures? Yes No

MARITAL STATUS MARRIED SINGLE DIVORCED WIDOWED **NUMBER OF CHILDREN** _____ None

Exercise regularly? Yes No If yes, what and how frequently?