PATIENT HISTORY FORM

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

Review of Systems (2 pages)

Circle **Yes** or **No.**

General Symptoms	NOW		PAST		(Comments)
Weight change	Y	N	Y	N	
Chills	Y	N	Y	N	
Sleep Disorder	Y	N	Y	N	
Other					

Eyes					
Double vision	Y	N	Y	N	
Glaucoma	Y	N	Y	N	
Cataracts	Y	N	Y	N	
Other					

Ear/Nose/Throat/Mouth					
Hearing changes	Y	N	Y	N	
Sore throat	Y	N	Y	N	
Sinus problem	Y	N	Y	N	
Other					

Cardiovascular					
Chest pain	Y	N	Y	N	
Irregular heartbeat	Y	N	Y	N	
Swelling in ankles	Y	N	Y	N	
Other					

Psychologic					
Are you generally happy?	Y	N	Y	N	
Do you feel depressed?	Y	N	Y	N	
Do you feel anxious?	Y	N	Y	N	
Do you feel safe in your home?	Y	N	Y	N	

Endocrine					
Excessive thirst	Y	N	Y	N	
Too hot/cold	Y	N	Y	N	
Tired/sluggish	Y	N	Y	N	
Other					

Hematologic/Lymphatic					
Swollen glands	Y	N	Y	N	
Blood clotting problem	Y	N	Y	N	
Bruising	Y	N	Y	N	
Other					

Allergic/Immune					
Hay Fever	Y	N	Y	N	
Drug allergies	Y	N	Y	N	
Food	Y	N	Y	N	
Other					

Genitourinary	NOW		PAST		(Comments)
Change in stream	Y	N	Y	N	
Nocturia (getting up at night)	Y	N	Y	N	
Urinary frequency > 8 times/day	Y	N	Y	N	
Other					

Musculoskeletal					
Bone pain	Y	N	Y	N	
Muscle pain	Y	N	Y	N	
Joint pain	Y	N	Y	N	
Other					

Skin					
Rash	Y	N	Y	N	
Lumps or bumps	Y	N	Y	N	
Moles, skin tags	Y	N	Y	N	
Other					

Neurological					
Tremors	Y	N	Y	N	
Dizzy spells	Y	N	Y	N	
Numbness/tingling	Y	N	Y	N	
Other					

Respiratory					
Wheezing	Y	N	Y	N	
Frequent cough	Y	N	Y	N	
Shortness of breath	Y	N	Y	N	
Other					

Gastrointestinal					
Abdominal pain	Y	N	Y	N	
Nausea/vomiting	Y	N	Y	N	
Indigestion/heartburn	Y	N	Y	N	
Other					

Sexual History		
Change in sex drive?	Y	N
Sexual performance satisfactory?	Y	N
Other (i.e. sexual trauma)		

Last Exams or Lab tests: Please enter date (mo/yr)

Dental: _____	Eye : _____
Pelvic: _____	PAP smear: _____
Mammogram: _____	Cholesterol: _____
Colonoscopy: _____	Stool Tested: _____
Prostate _____	PSA test: _____

Living Will? ☐ Yes ☐ No Advanced Directive? ☐ Yes ☐ No Doctor's signature: _____

(Please Complete Other Side)

Medical History

Medical ☐ None (*High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.*)

Pregnancy History

Year	Sex	Complications

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: ☐ **None**

Name of drug	mg dose	# tablets	# times per day

Additional current prescription medicines:

Name of drug	mg dose	# tablets	# times per day

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) (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?