Patient History

Patient Name: ________________________________Date: ________________________

Past Medical History (Please list any major medical problems you see doctors, or take medicine, or hospitalized for)

1. ________________________________ 2. ________________________________
3. ________________________________ 4. ________________________________
5. ________________________________ 6. ________________________________
7. ________________________________ 8. ________________________________
9. ________________________________ 10. ________________________________

Past Surgical History (Please list all of the surgical procedures you have before and date of surgery)

1. ____
2. ____
3. ____
4. ____
5. ____

Medications (Including nonprescription drugs)

1. ________________________________ 2. ________________________________
3. ________________________________ 4. ________________________________
5. ________________________________ 6. ________________________________
7. ________________________________ 8. ________________________________
9. ________________________________ 10. ________________________________

Please list all the physicians whose care you are under:

Primary Care Physician ________________________Internist____________________________

Gynecologist________________________________Others____________________________

Social History

Marital Status	Single:_______	Married:______	Divorced: ______	Widowed:________
Use of alcohol	Never:______	Rarely:_______	Moderate: ______	Daily:___________
Use of tobacco	Never:______	Current packs per day: _________	Quit: ___________	
Use of drugs	Never:______	Type/Frequency:______________________________		

Family Medical History

	Age	Diseases	If deceased, Cause of death
Father	_______	________________________	________________________
Mother	_______	________________________	________________________
Siblings	_______	________________________	________________________
	_______	________________________	________________________
	_______	________________________	________________________
	_______	________________________	________________________
Spouse	_______	________________________	________________________
Children	_______	________________________	________________________
	_______	________________________	________________________
	_______	________________________	________________________

Review of Systems

☐ **Constitutional Symptoms**
- 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/contact lenses .... No Yes
- Blurred or double vision .... No Yes

☐ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing .... No..Yes
- Earaches or drainage .... No..Yes
- Chronic sinus problem or rhinitis .... 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 pain or angina pectoris .... No Yes
- Palpitation .... No Yes
- Shortness of breath w/walking or lying flat .... No Yes
- Swelling of feet, ankles or hands .... No Yes

☐ **Respiratory**
- Chronic or frequent coughs .... No Yes
- Spitting up blood .... No Yes
- Shortness of breath .... No Yes
- Wheezing .... No Yes

☐ **Gastrointestinal**
- Loss of appetite .... No Yes
- Change in bowel movements .... No Yes
- Nausea or vomiting .... No Yes
- Frequent diarrhea .... No Yes
- Painful bowel movements or constipation .... No Yes
- Rectal bleeding or blood in stool .... No Yes
- Abdominal pain .... No Yes

☐ **Genitourinary**
- Frequent urination .... No Yes
- Burning or painful urination .... No Yes
- Blood in urine .... No Yes
- Change in force of strain when urinating .... No Yes
- Incontinence or dribbling .... No Yes
- Kidney stones .... No Yes
- Sexual difficulty .... No Yes
- Male – testicle pain .... No Yes
- Female – pain with periods .... No Yes
- Female – irregular periods .... No Yes
- Female – vaginal discharge .... No Yes
- Female - # of pregnancies .... _______
- Female - # of miscarriages .... _______
- Female – date of last pap smear .... _______

☐ 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

☐ Integumentary (skin, breast)
- 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 or recurring headaches .... No Yes
- Light headed or dizzy .... No Yes
- Convulsions or seizures .... No Yes
- Numbness or tingling sensations .... No Yes
- Tremors .... No Yes
- Paralysis .... No Yes
- Head injury .... No Yes

☐ **Psychiatric**
- Memory loss or confusion .... No Yes
- Nervousness .... No Yes
- Depression .... No Yes
- Insomnia .... No Yes
- Suicidal Thoughts .... No Yes
- Violent or Unusual Thoughts .... No Yes

☐ **Endocrine**
- Glandular or hormone problem ….No Yes
- Excessive thirst or urination .... No Yes
- Heat or cold intolerance .... No Yes
- Skin becoming drier .... No Yes
- Change in hat or glove size .... No Yes

☐ **Hematologic/Lymphatic**
- Slow to heal after cuts .... No Yes
- Bleeding or bruising tendency .... No Yes
- Anemia .... No Yes
- Phlebitis .... No Yes
- Past transfusion .... No Yes
- Enlarged glands .... No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics .... No Yes
- Morphine, Demerol, or other narcotics .... No Yes
- Novocain or other anesthetics .... No Yes
- Aspirin or other pain remedies .... No Yes
- Tetanus antitoxin or other serums .... No Yes
- Iodine, Merthiolate or other anteseptic .... No Yes
- Other drugs/medications: ___________ _______________________________
- Known food allergies:_____________ _______________________________
- Environmental allergies: ___________ _______________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ______________________

Signature of Patient or Guardian Date