

# Patient History Form

Name	DOB	Marital Status S M D W	Social Security	Home Ph  Cell Ph
<b>Pharmacy Name &amp; Address:</b>  <b>Phone:</b>	<b>Emergency Contact:</b> Name  Phone  Relationship		<b>Home Address: (Also put mailing address if different)</b>	
<b>Email Address:</b>	<b>Name of Insurance:</b>		<b>Employer Name and Address:</b>	
<b>Primary Care Physician:</b>  <b>Phone:</b>	<b>Referring Physician:</b>  <b>Phone:</b>		<b>Other Doctors involved in your care:</b>  <b>Phone:</b>	

**Reason for your visit** \_\_\_\_\_

## Review of Systems

Do you have any of the following? If yes, please circle all that apply and explain in the space provided. Is your family physician aware of all symptoms/illnesses that you have checked below? Yes/No

### General

Recent weight loss  
Recent weight gain  
Fever  
Night sweats  
Fatigue/weakness  
Loss of appetite

### Ophthalmology

Blurred vision  
Diminished vision  
Cataracts  
Glaucoma  
Red, painful eyes

### ENT

Sore throat  
Hoarseness  
Nose bleeds  
Loose teeth  
Mouth ulcers

### Respiratory

Chronic cough  
Shortness of breath  
Asthma  
Wheezing

### Psychiatry

Anxiety  
Depression  
Psychosis  
Tension/stress

Alcoholism

Substance abuse

### Gastroenterology

Heartburn  
Difficulty swallowing  
Abdominal pain  
Bloating/belching  
Nausea  
Vomiting  
Constipation  
Diarrhea  
Blood in stool  
Black stool  
Change in bowel habits  
Peptic ulcer  
Irritable bowel  
Crohn's disease  
Ulcerative colitis  
Polyps  
Liver disease  
Hepatitis  
Pancreatitis

### Hematology

Past transfusion  
Anemia  
Easy bruising/bleeding

### Dermatology

Itching  
Rash

### Musculoskeletal

Arthritis  
Muscle disease  
Back pain

### Genitourinary

Blood in urine  
Difficulty urinating  
Kidney disease  
Heavy periods  
Bleeding between periods

### Neurology

Previous stroke  
Headache  
Numbness/tingling  
Dizziness  
Seizure  
Memory loss  
Sleep disturbance

### Endocrinology

Excessive thirst  
Heat intolerance  
Cold intolerance

Hair loss

### Cardiology

Chest pain  
Palpitation  
Irregular heartbeat

## Past History

Please explain any "yes" answers in detailed description in the box provided.

Have you ever had any surgery or medical conditions?	Y	Surgeries	Dates	Medical Conditions	Dates		
	N						
Have you had any problems with anesthesia? If yes please list below:	Y						
	N						
Are you currently taking any medications or drugs (including OTC, Rx, or birth control)	Y	Medication:	Dose:	Times:	Medication:	Dose:	Times:
	N						

**Do you have any allergies (including environmental, medication, food and reaction to previous blood transfusion)? Y/N**

**Please explain:**

## Social History

Are you currently or have you ever used any tobacco or alcohol products? Yes / No

**Alcohol:** What type \_\_\_\_\_ How many drinks **per day** \_\_\_\_\_ **per week** \_\_\_\_\_ How many years \_\_\_\_\_

**Tobacco:** How many packs **per day** \_\_\_\_\_ How many years \_\_\_\_\_

Are you currently or have you ever used recreational/illicit drugs? Yes / No

For how long \_\_\_\_\_ What kind \_\_\_\_\_

## Family History:

Please indicate if your parents, siblings and/or children have had any of the following conditions:

Condition	Relationship	Condition	Relationship	Condition	Relationship
Colon/Rectal Cancer No Yes		Pancreatic Cancer No Yes		Peptic Ulcer Disease No Yes	
Colon Polyps No Yes		Uterine Cancer No Yes		Celiac Disease No Yes	
Stomach Cancer No Yes		Ovarian Cancer No Yes		Crohn's Disease or Ulcerative Colitis No Yes	
Small Intestine Cancer No Yes		Kidney Cancer No Yes		Heart Disease No Yes	

Person completing this form \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_