

Patient History Form

| | | | | |
|-------------------------------------|------------|--|------------------------|--|
| Name | DOB | Marital Status S M D W | Social Security | Home Ph Cell Ph |
| Pharmacy Name & Address: | | Emergency Contact: Name Phone Relationship | | Home Address: (Also put mailing address if different) |
| Phone: | | Race/Ethnicity: Preferred Language: | | Employer Name and Address: |
| Email Address: | | Referring Physician: | | Other Doctors involved in your care: |
| Primary Care Physician: | | Phone: | | Phone: |

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 _____