Patient History Form

Name	DOB	Marital Status S M D W	Preferred Name to Address You By:	Home Ph Cell Ph

Pharmacy Name & Address: Phone:	Emergency Contact: Name Phone Relationship	Home Address: (Also put mailing address if different)
Email Address:	Race/Ethnicity: Preferred Language:	Employer Name and Address:
Primary Care Physician: Phone:	Referring Physician: Phone:	Other Doctors involved in your care: 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 N	Surgeries	Dates		Medical Conditions	Dates	
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 N	Medication:	Dose:	Times:	Medication:	Dose:	Times

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 _____