

**PATIENT HISTORY FORM. PLEASE COMPLETE ALL AREAS TO THE BEST OF YOU KNOWLEDGE**

**NAME**

**DATE**      /      /

Occupation
Married/Single/Divorced
Children
Educational Level
Do You Have a Living Will      Y / N
Any Other Household Members?

**Listed below are common medical conditions. If either you or a family member has now or has ever had in the past any of these conditions, put a ✓ in the box by the condition listed. Then, next to the problem list the name of the individual who has the condition:**

Self	Family (check one or both) If family member please list	Self	Family		
<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer :	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis :
<input type="checkbox"/>	<input type="checkbox"/>	Cervical Cancer :	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis :
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer :	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems :
<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer :	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems :
<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer :	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems :
<input type="checkbox"/>	<input type="checkbox"/>	Other Cancer :	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems :
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack :	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems :
<input type="checkbox"/>	<input type="checkbox"/>	Heart Bypass surgery :	<input type="checkbox"/>	<input type="checkbox"/>	Change in Bowels :
<input type="checkbox"/>	<input type="checkbox"/>	Heart Balloon Surgery :	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool :
<input type="checkbox"/>	<input type="checkbox"/>	Leg Swelling :	<input type="checkbox"/>	<input type="checkbox"/>	Dark Tarry Stool :
<input type="checkbox"/>	<input type="checkbox"/>	Stroke :	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease :
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol :	<input type="checkbox"/>	<input type="checkbox"/>	Depression :
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes :	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks :
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure :	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox :
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema :	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis :
<input type="checkbox"/>	<input type="checkbox"/>	Asthma :	<input type="checkbox"/>	<input type="checkbox"/>	Measles :
<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems :	<input type="checkbox"/>	<input type="checkbox"/>	Mumps :
<input type="checkbox"/>	<input type="checkbox"/>	Seizures :	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches :

**Please list month and year of your most recent immunizations**

___/___ Hepatitis A	___/___ Measles	___/___ Tetanus*
___/___ Hepatitis B	___/___ Pneumonia*	___/___ Chicken Pox
___/___ Flu Shot**	___/___ Other	

\*Recommended every 10 years    \*\*Recommended every year

**Please ✓ if you have now or have had in the past any of the habits listed below. If you have quit, please indicate when you did quit.**

<input type="checkbox"/> Illicit Drugs: What Type?	<input type="checkbox"/> Alcohol: What type?	Amount
<input type="checkbox"/> Caffeine: Amount	<input type="checkbox"/> Tobacco: What type?	Amount
<input type="checkbox"/> Use Seat Belts	<input type="checkbox"/> Regular Exercise	

**Are there any other physicians currently involved in your care? If so, please list with speciality:**

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**Systems Review: Please list problems you have with any of the following**

Eyes	Ear/Nose/Throat
Heart	Lungs
Chest	Breasts
Abdomen	Genitals
Skin	Joints/back
Arms/Legs	Neurologic

**Please list any Surgeries you have had**

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

**Please list all medications you are on, including vitamins, herbal supplements, and contraception**

1.	7.	13.
2.	8.	14.
3.	9.	15.
4.	10.	16.
5.	11.	17.
6.	12.	18.

**Please list all medications you are allergic to and what happens. If you have no allergies please check this box  None**

1.	5.
2.	6.
3.	7.
4.	8.

**For *Women* please fill in the following information:**

Number of Pregnancies _____	Children _____	Miscarriages _____	Abortions _____
Date of last period ____/____	Could you be pregnant now? Y/N		
Last Pap Smear/Female exam: ____/____	<i>(Recommended yearly after age 18)</i>		
Last Mammogram: ____/____	<i>(Recommended yearly after age 40)</i>		
Method of Birth Control: _____	Age at first period/menopause: _____		
Have you ever had an abnormal Pap Smear? Y/N			

**For *Men* please fill in the following information:**

Last PSA (blood Prostate level): ____/____	<i>(Screening may begin yearly at age 50)</i>		
<input checked="" type="checkbox"/> If you have: <input type="checkbox"/> Weak urine stream <input type="checkbox"/> Prostate problems	<input type="checkbox"/> Lumps on testicles	<input type="checkbox"/> Pain on testicles	

**For *Men* and *Women* please fill in the following information:**

Last rectal Exam: ____/____	<i>(Recommended yearly after age 40)</i>
Last Flexible Sigmoidoscopy: ____/____	<i>(Recommended every 3-5 years after age 50)</i>

Your signature below indicates that you have read and answered all of the questions to the best of you knowledge. Thank You.

**Patients Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Physicians Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_