

PATIENT HISTORY FORM

Date:

Last Name		First Name		MI	Date of Birth
Marital Status: Single, Divorced, Married, Widow/Widower				Who Lives With You?	
Employer		Occupation		What kind of work?	
Primary Care Physician			Other doctors involved with your care:		

REVIEW OF SYSTEMS

Has the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Is your family physician aware of any symptoms/illnesses that you have checked below? Yes No

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Gastrointestinal			Cardiac			Neurologic			Ear, Nose, & Throat		
Diarrhea			High blood pressure			Seizures			Loose Teeth		
Constipation			Low blood pressure			Weakness			Nosebleeds		
Rectal Bleeding			Irregular heartbeat			Migraines			Deafness		
Change in BM's			Chest pain			Previous stroke			Psychosocial		
Weight loss			Respiratory			Musculoskeletal			Alcoholism		
Polyps			Asthma			Muscle Disease			Substance Abuse		
Irritable Bowel			Pneumonia			Arthritis			Depression		
Crohn's Disease			Bronchitis			Neck pain			Anxiety disorders		
Ulcerative Colitis			Chronic Cough			Back pain			Breast		
Trouble swallowing			Hoarseness			Blood Disorders			Lumps		
Nausea/Vomiting			Tracheostomy			Skin			Cancer		
Heartburn			Genitourinary			Rash			Please list below:		
Abdominal Pain			Kidney Disease			Bruises			Any symptoms/disease not listed above?		
Hepatic			Frequent urine infection			Ophthalmic					
Liver Disease			Endocrine/Metabolic			Cataracts					
Hepatitis			Diabetes			Glaucoma					
Pancreatitis			Thyroid Disorders			Blindness					

PAST HISTORY

Please explain any YES answers in detailed description in the box provided.

Have you ever had any surgery or been Hospitalized? No ___ Yes ___ If yes, please list below:	<input type="radio"/> No <input type="radio"/> Yes	<u>Surgeries</u> _____ _____ _____	<u>Dates</u> _____ _____ _____	<u>Hospitalizations other than surgery</u> _____ _____ _____	<u>Dates</u> _____ _____ _____		
	Have you had any problems with anesthesia? No ___ Yes ___ If yes, please list below:	<input type="radio"/> No <input type="radio"/> Yes	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	
Are you currently or have you ever used any Tobacco or alcohol products?	<input type="radio"/> No <input type="radio"/> Yes	Alcohol: How many drinks? <input type="radio"/> per day ___ <input type="radio"/> per week ___ <input type="radio"/> per month ___ Tobacco: How many packs per day? ___ pk(s) For how many years? ___ yr(s)					
Are you or have you ever used recreational/illicit drugs?	<input type="radio"/> No <input type="radio"/> Yes	If yes, what kind? _____ For how long? _____					
Are you currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	<input type="radio"/> No <input type="radio"/> Yes	Medication _____ _____ _____	Dose _____ _____ _____	Times _____ _____ _____	Medication _____ _____ _____	Dose _____ _____ _____	Times _____ _____ _____
Do you have any allergies (including, environmental, medication, food, and reaction to previous blood trasfusion)?	<input type="radio"/> No <input type="radio"/> Yes	_____ _____ _____					

FAMILY HISTORY: Please indicate if your parents brothers, sisters and/or children have had any of the following conditions:

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Colon/Rectal Cancer No ___ Yes ___		Kidney problems No ___ Yes ___		Heart Disease No ___ Yes ___	
Stomach Cancer No ___ Yes ___		Ulcerative Colitis No ___ Yes ___		Crohn's Disease No ___ Yes ___	
Breast Cancer No ___ Yes ___		Ovarian Cancer No ___ Yes ___		Bleeding Problems No ___ Yes ___	

Person Completing This Form/Relationship to Patient

Reviewed by Provider

Date(s)