Patient Name: ____ DOB: _______________

FAMILY HISTORY	List other illnesses in your family (Example-diabetes, heart disease, colon cancer, breast cancer, prostate cancer, renal cancer, kidney stones, etc)
Father: ☐ Living-Age: ______ ☐ Deceased, age at death _____	Family Member ______________ Illness ______________
(Cause) ______________________________	______________ ______________
Mother: ☐ Living-Age: ______ ☐ Deceased, age at death _____	______________ ______________
(Cause) ______________________________	______________ ______________
Siblings: # Living ________ Number deceased ________	
(Cause) ______________________________	

MEDICAL HISTORY

MEDICAL PROBLEMS (High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.) ☐ None

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

SURGICAL PROCEDURES (Type and year - Example: Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.) ☐ None

______________/______ ______________/______ ______________/______

______________/______ ______________/______ ______________/______

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Alcohol? ☐ Yes ☐ No If yes, how much?
Number of Children: ________ ☐ None	______________________________
Have you ever smoked? ☐ Yes ☐ No	Occupation: ______________________ ☐ Retired
If yes, how much? _____ # of packs/day _____ # of years	Exercise regularly? ☐ Yes ☐ No
When did you stop smoking? ____________	If yes, what and how frequently? ______________

CURRENT prescription medicines: ☐ None

Name of Drug	Dosage	Name of Drug	Dosage

CURRENT Non-Prescription Medicines:
(Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals)

____

____

PHYSICIAN COMMENTS/History of Illness

____

____

____

____

____

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

NAME ______________________________

TELEPHONE __________________________

D.O.B. ________________ AGE __________

Date: ______________________

Dr.: ______________________

Referred By: ______________________

Date of last visit: ______________________

CHIEF COMPLAINT - What is the reason for your visit today?

____

____

____

Review of Systems

Do you now or have you had any problems related to the following systems?

Constitutional Symptoms			**Comments**
Weight Change	Yes	No	
Chills	Yes	No	
Sleep Disorder	Yes	No	
Other	Yes	No	
Eyes			
Glaucoma	Yes	No	
Cataracts	Yes	No	
Other	Yes	No	
Ear/Nose/Throat/Mouth			
Hearing changes	Yes	No	
Sore throat	Yes	No	
Sinus problem	Yes	No	
Other			
Cardiovascular			
Chest pain	Yes	No	
Irregular heartbeat	Yes	No	
Swelling in ankles	Yes	No	
Other	Yes	No	
Psychological			
Anxiety	Yes	No	
Depression	Yes	No	
Endocrine			
Excessive thirst	Yes	No	
Too hot	Yes	No	
Too cold	Yes	No	
Other			
Hematologic/Lymphatic			
Swollen glands	Yes	No	
Blood clotting problem	Yes	No	
Bruising	Yes	No	
Other	Yes	No	

Height: ____________________

Weight: ____________________

Genitourinary			**Comments**
Change in stream	Yes	No	
Blood in urine	Yes	No	
Burning with urination	Yes	No	
Getting up at night to void	Yes	No	
Incontinence (Leakage)	Yes	No	
Other	Yes	No	
Musculoskeletal			
Bone pain	Yes	No	
Muscle pain	Yes	No	
Joint pain	Yes	No	
Other	Yes	No	
Integumentary (Skin)			
Rash	Yes	No	
Lumps or bumps	Yes	No	
Moles, skin tags	Yes	No	
Other	Yes	No	
Neurological			
Tremors	Yes	No	
Dizzy spells	Yes	No	
Numbness/tingling	Yes	No	
Other	Yes	No	
Respiratory			
Wheezing	Yes	No	
Frequent cough	Yes	No	
Shortness of breath	Yes	No	
Other	Yes	No	
Gastrointestinal			
Abdominal pain	Yes	No	
Nausea	Yes	No	
Vomiting	Yes	No	
Indigestion	Yes	No	
Heartburn	Yes	No	
Constipation	Yes	No	
Diarrhea	Yes	No	
Other			
Sexual History			
Change in sex drive?	Yes	No	
Sexual performance satisfactory?	Yes	No	
Other	Yes	No	

ALLERGIES TO MEDICATIONS? ❒ None ______________________________