PATIENT FORM – MEDICAL HISTORY

Name: _____ **DOB:** _____

Who is your Primary Care Physician: _____
Which other physicians do you see: _____

CHIEF COMPLAINT

Describe briefly what you need to be seen for. (If establishing a new primary care physician please list 'Establish Care'.)_____

MEDICATIONS

List all medications that you are currently taking (including non-prescription medications, herbal medications, vitamins or nutritional supplements)

Drug	Dose:	How often:	Prescribed by:

HEALTH MAINTENANCE

Do you use Caffeine? Yes ☐ No ☐
Do you smoke/chew tobacco? Yes ☐ No ☐ If yes, how many packs/day? _____ How many years? _____
If you previously smoked/chewed tobacco, _____ packs/day for _____ years.
Do you drink alcohol? Yes ☐ No ☐ Number of drinks/week and type?_____
If you previously drank alcohol, when did you stop? _____/_____/_____

Do you have any allergies? Yes ☐ No ☐ (If yes, see below)

Please list all allergies:	**Type of Reaction:**
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY

PAIN ASSESMENT

Do you have any chronic pain issues? Yes ☐ No ☐

If yes, please list location (i.e., low back, shoulder, knee) _____

What are you doing to decrease your pain? _____

_____

If seen for pain management please list physician and/or facility you are treated at? _____

_____

Do you have or have had any of the following medical conditions?

			If yes, describe Treatment:
High Blood Pressure	Yes ☐	No ☐	_____
Heart Attack	Yes ☐	No ☐	_____
Congestive Heart failure	Yes ☐	No ☐	_____
Pneumonia	Yes ☐	No ☐	_____
Asthma	Yes ☐	No ☐	_____
Pyelonephritis	Yes ☐	No ☐	_____
Emphysema	Yes ☐	No ☐	_____
Tuberculosis	Yes ☐	No ☐	_____
Thyroid	Yes ☐	No ☐	_____
Blood Disease	Yes ☐	No ☐	_____
Blood Clots	Yes ☐	No ☐	**Location of Clots**: _____
Cancer	Yes ☐	No ☐	_____
Phlebitis	Yes ☐	No ☐	_____
Ulcer	Yes ☐	No ☐	_____
Hepatitis	Yes ☐	No ☐	_____
Crohn's Disease or Colitis	Yes ☐	No ☐	_____
Cirrhosis	Yes ☐	No ☐	_____
Kidney Stones	Yes ☐	No ☐	_____
Arthritis	Yes ☐	No ☐	_____
Stroke	Yes ☐	No ☐	_____
Diabetes	Yes ☐	No ☐	_____
Epilepsy	Yes ☐	No ☐	_____
Varicose Veins	Yes ☐	No ☐	_____
Gout	Yes ☐	No ☐	_____
Other	Yes ☐	No ☐	_____

SURGICAL HISTORY

☐ Appendix
☐ Bladder Suspension
☐ Blood Vessel Surgery
  ☐ Arteries
  ☐ Veins
☐ Colon/Rectal Surgery
☐ Dental Surgery
☐ Eye Surgery
☐ Fracture location: _____
☐ Gallbladder
☐ Heart Surgery
  ☐ Bypass
  ☐ Heart valve surgery
  ☐ Angioplasty
  ☐ Stent
  ☐ Pacemaker
☐ Hernia
☐ Hysterectomy
  ☐ Complete ☐ Partial
☐ Joint replacement/Orthopedic surgery (please circle one)
☐ Kidney surgery
☐ Organ Transplant
☐ Prostate Surgery
☐ Sinus Surgery
☐ Thyroidectomy
☐ Tonsils and/or Adenoids
☐ Tubal Ligation
☐ Vasectomy

FAMILY HISTORY

	Relationship						
	Mother	Father	Sister	Brother	Maternal/Paternal Grandmother	Maternal/Paternal Grandfather	
Cancer	☐	☐	☐	☐	☐☐	☐☐	**Type:** _____
Heart Attack	☐	☐	☐	☐	☐☐	☐☐	
Congestive Heart Failure	☐	☐	☐	☐	☐☐	☐☐	
Emphysema	☐	☐	☐	☐	☐☐	☐☐	
Asthma	☐	☐	☐	☐	☐☐	☐☐	
Tuberculosis	☐	☐	☐	☐	☐☐	☐☐	
Ulcer/Colitis	☐	☐	☐	☐	☐☐	☐☐	**Type:** _____
Liver Disease	☐	☐	☐	☐	☐☐	☐☐	**Type:** _____
Blood Clots	☐	☐	☐	☐	☐☐	☐☐	**Type:** _____
Kidney Disease	☐	☐	☐	☐	☐☐	☐☐	**Type:** _____
Crohn's Disease	☐	☐	☐	☐	☐☐	☐☐	
MS	☐	☐	☐	☐	☐☐	☐☐	
Thyroid Disease	☐	☐	☐	☐	☐☐	☐☐	**Type:** _____
Diabetes	☐	☐	☐	☐	☐☐	☐☐	**Type:** _____
Seizure Disorder	☐	☐	☐	☐	☐☐	☐☐	**Type:** _____
Stroke	☐	☐	☐	☐	☐☐	☐☐	**Type:** _____
Blood Disease	☐	☐	☐	☐	☐☐	☐☐	**Type:** _____

PSYCHIATRIC CONDITIONS

			Additional Comments
Depression	Yes☐	No☐	_____
Emotional/Problems	Yes☐	No☐	_____
Stress:	Yes☐	No☐	_____
Other Problems	Yes☐	No☐	_____

PREVENTATIVE CARE

Date of last Colon and Rectal Screening: _____
Have you had a bone density (DEXA) exam? Yes ☐ No ☐ Date: _____
Date of last eye exam: _____ Date of last dental exam: _____

IMMUNIZATIONS

	DATE:		DATE:		DATE:
Tetanus	_____	Whooping Cough	_____	Shingles	_____
Influenza/Flu	_____	Hepatitis A	_____	HPV	_____
Pneumonia	_____	Hepatitis B			

For our FEMALE patients only:

Date of last menstrual period: _____
Do you have a Gynecologist? Yes☐ No☐ If yes, Gynecologist name:_____
Date of last PAP test: _____ Date of last mammogram: _____
Have you gone through menopause? Yes☐ No☐
Menstrual problems: ☐Irregular ☐Heavy ☐Change in frequency _____
Number of pregnancies: _____Number of live births:_____ Current birth control method:_____

For our MALE patients only:

Date of last PSA test: _____ Date of last rectal exam: _____

For our PEDIATRIC patients only: (Please answer from the child's perspective)

What is the current marital status of the child's parents?
☐Married ☐Single ☐Divorced ☐Separated ☐Widow ☐Widower

Who does the child primarily reside with? ☐ Both Parents ☐Mother ☐Father ☐Other: _____
Does the child have siblings: Yes☐ No☐ If yes, # of brothers_____ # of sisters _____
Does your child attend daycare? Yes☐ No☐ If yes, average # of days per week _____
If school age, current grad in school: _____

REVIEW OF SYSTEMS

General
☐Chills
☐Fatigue
☐Fever
☐Night sweats
☐Weakness
☐Weight loss/gain
☐Other: _____

Head and Neck
☐Ear drainage
☐Ear pain
☐Eye discharge
☐Eye pain
☐Hearing loss
☐Nasal drainage
☐Sinus pressure
☐Sore throat
☐Visual changes
☐Double vision
☐Foreign body sensation
☐Light sensitivity
☐Eye dryness
☐Ear injections
☐Snoring
☐Loss of smell
☐Nosebleeds
☐Change in taste
☐Voice change
☐Sores in mouth/throat
☐Lump in throat

Resiratory
☐Chest Pain (respiratory)
☐Cough
☐Shortness of breath
☐Known TB exposure
☐Wheezing

Cardiovascular
☐Irregular heartbeat
☐Chest Pain
☐Leg swelling
☐Fainting

Gastrointestinal
☐Abdominal pain
☐Constipation
☐Black tarry stools
☐Diarrhea
☐Heartburn
☐Jaundice
☐Loss of appetite
☐Nausea
☐Vomiting
☐Easy Bleeding

Musculoskeletal
☐Joint swelling
☐Joint pain
☐Muscle weakness
☐Neck Pain
☐Back pain
Other:_____

Metabolic/Endocrine
☐Cold intolerance
☐Heat intolerance
☐Excessive thirst
☐Excessive hunger
Other: _____

Neurological
☐Tremors
☐Seizures
☐Dizziness
☐Extremity numbness
☐Extremity weakness
☐Gait disturbance
☐Headache
☐Memory loss
Other:_____

Psychiatric
☐Anxiety
☐Depression
☐Insomnia

Hematologic
☐Itching
☐Easy bruising
☐Swollen lymph node
Other:_____

Female Patients
☐Abnormal Pap
☐Painful menses
☐Hot flashes
☐Irregular menses
☐Vaginal discharge
Other:_____

Male Patients
☐Erectile Dysfunction
☐Penile discharge
☐Sexual Dysfunction
Other:_____

Skin/Hair
☐Ringing/buzzing in ears
☐Mole changes
☐Skin lesion
☐Breast lump
☐Breast discharge
☐Brittle hair
☐Brittle nails
☐Hair loss
☐Excessive hair
☐Hives
Other: _____

Urinary
☐Incontinence
☐Pain with urination
☐Frequent urination
☐Blood in urine