

PATIENT HISTORY FORM

This form has been designed in an attempt to make the best use of your time and our time in dealing with your health needs. Your thoughtfulness in completing it is appreciated.

NAME _____ AGE _____ SEX _____ MARITAL STATUS _____

Please describe the problem(s) for which you are currently seeking our help: _____

When did this problem begin? _____

Has it been treated before? Yes ___ No ___ If yes, by whom? _____

What makes it better? _____

What makes it worse? _____

Please list all surgeries and approximate dates: _____

Please list all serious illnesses or injuries and approximate dates: _____

Please list childhood illnesses which you have had: _____

Please list all medications which you are currently taking: _____

Please list any medications you cannot take or those in which you are allergic: _____

Employer: _____

Briefly describe your work: _____

Do you feel fulfilled by your work? _____

Have you had any alcohol in the last 48 hours? Yes ___ No ___

Do you use tobacco? Yes ___ No ___ Smoke? Yes ___ No ___ Do you drink coffee? Yes ___ No ___

Do you rest well? Yes ___ No ___ Do you eat regularly? Yes ___ No ___ Do you exercise regularly? Yes ___ No ___

Have you ever been turned down for life insurance, military service, or employment because of health problems? Yes ___ No ___

Have you ever received disability compensation? Yes ___ No ___

How do you perceive your health? Excellent ___ Good ___ Fair ___ Poor ___

Where do you attend church? _____

Are you happy with your marriage? _____ Are you happy with your sex life? _____

Please list your children: _____, _____, _____, _____, _____

Do you have any other concerns? _____

When was your last complete physical? _____ By Whom? _____

Please **CHECK** below if a blood relative has had any of the above:

<input type="checkbox"/>	diabetes	<input type="checkbox"/>	hypoglycemia	<input type="checkbox"/>	free bleeding
<input type="checkbox"/>	heart disease	<input type="checkbox"/>	thyroid disorder	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	kidney or bladder trouble	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	stroke	<input type="checkbox"/>	familial blood disorder	<input type="checkbox"/>	mental illness
<input type="checkbox"/>	cancer	<input type="checkbox"/>	stomach or colon trouble	<input type="checkbox"/>	bipolar disorder
<input type="checkbox"/>	asthma	<input type="checkbox"/>	ulcers	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	elevated Cholesterol	<input type="checkbox"/>	anemia	<input type="checkbox"/>	Depression
<input type="checkbox"/>	allergies	<input type="checkbox"/>	jaundice	<input type="checkbox"/>	Suicide
<input type="checkbox"/>	glaucoma	<input type="checkbox"/>	gout	<input type="checkbox"/>	

Please **CIRCLE** if you have personally experienced any of the above listed disorders.

This form was reviewed on _____ by _____.

General Symptoms

- ___ chills
- ___ fainting
- ___ dizziness
- ___ voice change
- ___ weakness
- ___ weight change
- ___ easy bruising
- ___ get cold easy
- ___ get hot easy
- ___ body hair change
- ___ excessive thirst
- ___ night sweats
- ___ growths or tumors
- ___ temperature or fever

Cardio Respiratory

- ___ cough
- ___ phlegm
- ___ coughing blood
- ___ wheezing
- ___ short of breath
- ___ asthma
- ___ bronchitis
- ___ emphysema
- ___ past pneumonia
- ___ pleurisy
- ___ tire easily
- ___ high blood pressure
- ___ heart disease
- ___ heart murmur
- ___ extra heart beats
- ___ swelling of feet

Chest Pain

- ___ with exercise
- ___ with deep breathing
- ___ at rest
- ___ take nitroglycerin
- ___ rheumatic fever
- ___ varicose veins
- ___ blood clots
- ___ racing heart
- ___ pain in legs
- ___ when walking
- ___ poor circulation
- ___ headaches
- ___ migraines
- ___ clumsiness
- ___ crying spells
- ___ constant anger

Neurologic:

- ___ paralysis
- ___ numbness
- ___ convulsions
- ___ depressed
- ___ worry a lot
- ___ get tense
- ___ poor memory
- ___ trembling & shaking
- ___ poor coordination

Skin

- ___ dry skin
- ___ brittle nails
- ___ itching
- ___ moles

- ___ rash
- ___ spots
- ___ warts
- ___ hives
- ___ lumps ill akin
- ___ athlete's foot
- ___ yellow skin
- ___ excessive perspiration

Eyes

- ___ glasses
- ___ contacts
- ___ double vision
- ___ see spots
- ___ watery eyes
- ___ loss of vision
- ___ night blindness
- ___ painful eyes
- ___ flushes of light

Blood

- ___ abnormal blood clotting
- ___ easy bleeding
- ___ anemia
- ___ prior transfusion

Nose

- ___ sinus trouble
- ___ hay fever
- ___ nose bleeds
- ___ can't smell
- ___ dryness, itching

Ears

- ___ painful in ears
- ___ hearing loss
- ___ buzzing in ears
- ___ ringing in ears
- ___ frequent infections

Mouth

- ___ painful teeth
- ___ painful tongue
- ___ dentures
- ___ difficulty swallowing
- ___ frequent sores in month

Musculoskeletal

- ___ painful joints
- ___ back trouble
- ___ neck trouble
- ___ broken bones
- ___ stiff joints
- ___ red, swollen joints

Behavioral:

- ___ irritable
- ___ difficulty sleeping
- ___ use marijuana
- ___ experiment with drugs
- ___ sex unsatisfactory
- ___ no sexual interest
- ___ pain with intercourse

Gastrointestinal

- ___ pain in abdomen
- ___ change ill bowel habits
- ___ gallbladder trouble
- ___ poor appetite
- ___ ulcers
- ___ colitis
- ___ jaundice
- ___ nausea

- ___ vomiting
- ___ vomit blood
- ___ diarrhea
- ___ constipation
- ___ blood in stools
- ___ black stools
- ___ piles or hemorrhoids
- ___ hernia
- ___ worms
- ___ trouble with pancreas
- ___ nervous stomach
- ___ bloating
- ___ belching/passing gas
- ___ indigestion/heartburn
- ___ itching in anal area

Genitourinary

- ___ frequent bladder infections
- ___ urinate more than normal
- ___ blood in urine
- ___ difficulty starting flow of urine
- ___ cannot control flow of urine
- ___ kidney stones
- ___ funny color of urine
- ___ had odor of urine
- ___ painful urination

For Men:

- ___ discharge from penis
- ___ difficulty with erection
- ___ painful erection
- ___ prostate trouble
- ___ painful testicles
- ___ lump on testicle
- ___ elevated PSA
- ___ vasectomy

For Women:

- ___ # of pregnancies
- ___ # of children
- ___ vaginal discharge
- ___ pain with periods
- ___ hysterectomy
- ___ hot flushes
- ___ breast trouble
- ___ lump in breast
- Periods began at _____ (age)
- Lost period began _____ (date)
- Lost pap smear _____ (date)
- Duration of period _____ (days)
- Periods every _____ (days)
- Birth Control: _____
- ___ pills
- ___ IUD
- ___ tubal ligation
- ___ other

Infections

- ___ Hepatitis
- ___ Herpes simplex
- ___ Tuberculosis
- ___ Immune Deficiency
- ___ other _____

Immunizations

- ___ Last Flu Vaccine _____ (date)
- ___ Last Pneumonia Vaccine _____ (year)

Please feel free to write down any other concerns you would like to discuss:
