PATIENT HISTORY

Name: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Your medical history is important to us in order to assist you with your medical concerns. This information is confidential and will become a permanent addition to your medical record.

Date of last physical exam: _____ Reason for today's visit: _____

Please check ANY of the following symptoms you currently have or have had in the past year:

GENERAL		GASTROINTESTINAL	EYE/EAR/NOSE/THROAT	MEN ONLY
Chills		Poor appetite	Bleeding gums	Erection difficulties
Depression/Nervousness		Bloating	Blurred vision	Lump in testicles
Dizziness/Fainting		Bowel changes	Crossed eyes	Penis discharge
Fever		Constipation	Difficulty swallowing	Sore on penis
Forgetfulness		Diarrhea	Double vision	Other
Headache		Excessive thirst	Earache/Ear discharge	**FEMALE ONLY**
Loss of sleep		Gas	Hay fever	Abnormal pap smear
Loss of weight		Hemorrhoids	Hoarseness	Bleeding between periods
Numbness		Indigestion	Loss of hearing	Breast Lump
Sweats		Nausea	Nosebleeds	Extreme menstrual pain
MUSCLE/JOINT/BONE (pain/ weakness/numbness in:)		Rectal bleeding	Persistent cough	Hot flashes
		Stomach pain	Ringing in ears	Nipple discharge
Arms	Hips	Vomiting	Sinus problems	Painful intercourse
Back	Legs	Vomiting blood	Vision-flashes/halos	Vaginal discharge
Feet	Neck	**CARDIOVASCULAR**	**SKIN**	Other
Hands	Shoulders	Chest pain	Bruise easily	Date of last menstrual period _____
		High/Low blood pressure	Hives	
GENITO-URINARY		Irregular/rapid heartbeat	Itching/Rash	Date of last pap smear: _____
		Poor circulation	Change in moles	
Blood in urine		Swelling of ankles	Scars	Have you had a mammogram? _____
Frequent urination		Varicose veins	Sore that won't heal	Are you pregnant? _____
Painful urination				Number of Children: _____

Please mark any surgeries that you have had, and include dates below:

SURGERY	DATE	SURGERY	DATE	SURGERY	DATE
Abdominal		Gallbladder		Urological	
Appendectomy		Heart		Breast	
Back/Neck		Joint Replacement (Site: _____)		Hysterectomy	
Biopsy		Tonsillectomy		C-Section	
Other		Other		Other	

Family History:

RELATION	ALIVE	DECEASED	**Medical Problems:** (i.e. high blood pressure, cholesterol, heart attack, stroke, thyroid disease, cancer, etc.)
Father			
Mother			
Siblings			
Grandparents			

List of Current Medications: If you have a long list of medication, please have the Front Desk copy your list of medications.

MEDICATION	DOSE (STRENGTH)	HOW OFTEN	FOR WHAT CONDITION?

Please list any ALLERGIES to medication and your REACTION to the medication below:

_____

_____

Preventive Healthcare Screening (when did you last have the following?):

Social History:

Do you smoke cigarettes? ___Yes ___No If yes, how much daily? _____ If no, did you ever ? ___Yes ____No

Do you drink alcohol? ___Yes ___No If yes, how often? _____ If no, did you ever ? ___Yes ____No

Female Only:

How many pregnancies? _____ How many births? _____ How many miscarriages? _____ Abortions? _____

Preventive Healthcare Screening (When did you last have the following?):

Test	Date/Year	Immunizations	Date/Year
Mammogram (Female)		Last Tetanus vaccine	
Pap Smear (Female)		Pneumonia Vaccine	
Bone Density Test		**Specialist(s) you are seeing**	**Name**
Cholesterol Test			
Colon/Sigmoid Screening			
Stress test:			

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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Print Name Date

_____ _____

Signature Date