

Patient History Form

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Name: _____ DOB: _____ Date: _____

What is the major reason for today's visit? _____

Personal History

Birthplace _____
Race _____
Marital Status _____
Occupations _____ Disabled _____
Street Drugs _____
Recreation/Hobbies _____
Exercise _____ How Often _____
Pets _____
Alcohol _____
Tobacco _____ How Long _____ Packs Per Day _____
Tea, Soda, Coffee _____
Traveling outside the country _____ When _____
Exposure to Toxic Chemicals (Radiation, Chemo, Asbestos, Other) _____

Medical History

Have you had any of the following? **Circle those which apply and give dates** where appropriate.

Measles/Mumps	Hay fever/sinusitis
Whooping Cough	Polio
Scarlet fever	Diphtheria
Meningitis	Infectious Mono
Valley Fever	Tuberculosis
Exposure to TB	Skin test positive to TB
Malaria	Hives
Pneumonia	Bronchitis
Pleurisy	Asthma
Emphysema	Rheumatic Fever
Arthritis	Back Trouble
Cancer Type _____	
Venereal disease	Glaucoma
High blood pressure	COPD
Heart disease	OSA
Heart attack/Stroke	Asthma-Age _____
Diabetes Juvenile	Emphysema
Diabetes adult onset	Chronic Bronchitis
Narcolepsy	Pulmonary Fibrosis
Seizure	Lung Cancer
Anemia	Cystic Fibrosis
Bleeding Tendency	Blood transfusion
Hepatitis (yellow jaundice)	Nose bleeds
Hemorrhoids	Ulcer
Bladder infections	Kidney disease

Surgical History

Have you had any of the following operations? **Circle those which apply and give dates** where appropriate.

Heart/Cath/Stent/Pacemaker
Coronary bypass surgery
Heart valve replacement
Tonsils
Appendix
Gall bladder
Stomach
Breast
Uterus and /or ovary
Prostate
Hernia
Thyroid
Varicose
Veins
Hemorrhoids
Other _____

Injury History

Have you had any of the following injuries? **Circle those which apply and give dates** where appropriate.

Head
Chest
Abdomen
Broken Bones
Back
Other _____

Allergies

Have you had allergies to any of the following? **Circle or complete which apply**

Tetanus antitoxin
Penicillin
Sulfa
Other drugs _____
Foods
Other _____

Immunizations

Have you had the following immunizations? **Circle those which apply and give dates where appropriate.**

- Smallpox
- Tetanus
- Polio
- Flu shot
- Pneumovax
- Other _____

Family History

Do you have a family history of any of the following medical conditions? **Circle those which apply and list relationship.**

- | | |
|----------------------|--------------------|
| Anemia | COPD |
| Bleeding Tendency | OSA |
| Leukemia | Asthma |
| Repeated infections | Pulmonary Fibrosis |
| Crippling infections | Cystic Fibrosis |
| Heart disease | Lung Cancer |
| Chronic lung disease | Emphysema |
| Tuberculosis | Chronic Bronchitis |
| High blood pressure | Narcolepsy |
| Kidney disease | Diabetes |
| Asthma | Severe allergies |
| Mental illness | Gout |
| Convulsions | Obesity |
| Migraine headaches | Thyroid trouble |
| Peptic ulcer | Chronic diarrhea |
| Cancer | |

Father Alive Deceased Age _____
 Causes of death _____
 Mother Alive Deceased Age _____
 Causes of death _____

Systems Review

Have you recently had the following?

- | General | Yes | No |
|---------------------|--------------------------|--------------------------|
| Tire easily | <input type="checkbox"/> | <input type="checkbox"/> |
| Weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Sensitivity to heat | <input type="checkbox"/> | <input type="checkbox"/> |
| Sensitivity to cold | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Gain | <input type="checkbox"/> | <input type="checkbox"/> |

Skin

- | | | |
|-----------------|--------------------------|--------------------------|
| Rash | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in color | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in hair | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in nails | <input type="checkbox"/> | <input type="checkbox"/> |

- | Eyes | Yes | No |
|----------------|--------------------------|--------------------------|
| Trouble seeing | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Inflamed eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| Double vision | <input type="checkbox"/> | <input type="checkbox"/> |
| Worn glasses | <input type="checkbox"/> | <input type="checkbox"/> |

- | Ears | Yes | No |
|---------------------|--------------------------|--------------------------|
| Loss of hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> |
| Discharge from ears | <input type="checkbox"/> | <input type="checkbox"/> |

- | Nose | Yes | No |
|------------------|--------------------------|--------------------------|
| Loss of smell | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent colds | <input type="checkbox"/> | <input type="checkbox"/> |
| Obstruction | <input type="checkbox"/> | <input type="checkbox"/> |
| Excess discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| Nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> |

- | Mouth | Yes | No |
|--------------------|--------------------------|--------------------------|
| Sore gums | <input type="checkbox"/> | <input type="checkbox"/> |
| Soreness of tongue | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental problems | <input type="checkbox"/> | <input type="checkbox"/> |

- | Throat | Yes | No |
|--------------------|--------------------------|--------------------------|
| Postnasal drainage | <input type="checkbox"/> | <input type="checkbox"/> |
| Soreness | <input type="checkbox"/> | <input type="checkbox"/> |
| Hoarseness | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in voice | <input type="checkbox"/> | <input type="checkbox"/> |

- | Breasts | Yes | No |
|-----------|--------------------------|--------------------------|
| Lumps | <input type="checkbox"/> | <input type="checkbox"/> |
| Discharge | <input type="checkbox"/> | <input type="checkbox"/> |

- | Heart | Yes | No |
|-----------------------------|--------------------------|--------------------------|
| Chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Palpitations | <input type="checkbox"/> | <input type="checkbox"/> |
| Short of breath while lying | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Vein problems | <input type="checkbox"/> | <input type="checkbox"/> |

- | Lungs | Yes | No |
|----------------------------|--------------------------|--------------------------|
| Cough | <input type="checkbox"/> | <input type="checkbox"/> |
| Sputum (phlegm) | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody sputum | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheezing | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain on breathing in chest | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| SOB with exertion | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling in ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| Bluish fingers or lips | <input type="checkbox"/> | <input type="checkbox"/> |

Abdomen	Yes	No
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>
Excess gas	<input type="checkbox"/>	<input type="checkbox"/>
Enlargement	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Bloody stools	<input type="checkbox"/>	<input type="checkbox"/>
Dark urine	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Need for laxatives	<input type="checkbox"/>	<input type="checkbox"/>
Kidney and Urinary		
Increase in urination at night	<input type="checkbox"/>	<input type="checkbox"/>
Unable to hold urine	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Lack of sex drive	<input type="checkbox"/>	<input type="checkbox"/>
Pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine		
Thyroid nodule or mass	<input type="checkbox"/>	<input type="checkbox"/>
High thyroid level	<input type="checkbox"/>	<input type="checkbox"/>
Low thyroid level	<input type="checkbox"/>	<input type="checkbox"/>
Adrenal trouble	<input type="checkbox"/>	<input type="checkbox"/>
High blood sugars	<input type="checkbox"/>	<input type="checkbox"/>
Low blood sugars	<input type="checkbox"/>	<input type="checkbox"/>
Muscular		
Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Pain in joints	<input type="checkbox"/>	<input type="checkbox"/>
Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Deformity of joints	<input type="checkbox"/>	<input type="checkbox"/>
Nervous System		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Change in sensation	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>

Sleep Disorders	Yes	No
Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Excessive daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>
Pauses in breathing during sleep	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Sleeplessness	<input type="checkbox"/>	<input type="checkbox"/>
Sleepiness while driving	<input type="checkbox"/>	<input type="checkbox"/>
Gyn-OB		
Pregnant _____		