Patient History

Name ____ **Today's Date** __________________________

Date of Birth ____ **Age** ________________________________

Primary Care Physician ____________________________________ **Referred by** _________________________

Reason for Visit____

Do you have radiology studies (x-ray, CT scan, MRI, Ultrasound) or lab results related to today's visit? Yes___ No ___

If yes, from which facility? __________________________________ Date of Service ___________________________

Allergies

Please list all allergies (i.e. latex, medications, radiology contrast dyes, food) and type of reaction:

____

____

____

Medications/Supplements

Please list medications, vitamins, and supplements you are currently taking.

____

____

Pharmacy Name, Address and Telephone Number

____

Name: ____________________ Date of Birth: ___________

Personal Medical History

Please circle the appropriate response regarding the following medical conditions you may have experienced.

Atrial Fibrillation	Yes No	Dementia	Yes No	Neurological Disorder	Yes No
Anemia	Yes No	Depression	Yes No	Pancreatitis	Yes No
Asthma	Yes No	Emphysema	Yes No	Rheumatic Fever	Yes No
Blood Transfusion	Yes No	GERD	Yes No	Seizures	Yes No
Cancer	Yes No	Glaucoma	Yes No	Sickle Cell Anemia	Yes No
Type ____________________		Heart Attack	Yes No	Substance Abuse	Yes No
____________________		Heart Murmur	Yes No	Stroke	Yes No
Cataracts	Yes No	HIV/AIDS	Yes No	Thyroid Disease	Yes No
CHF	Yes No	Hypertension	Yes No	Tuberculosis	Yes No
Clotting Disorders	Yes No	Kidney Disease	Yes No	Ulcers	Yes No
COPD	Yes No	Meningitis	Yes No	Other ______________________	
Coronary Artery Disease	Yes No	Muscle Disorder	Yes No	____________________________	

Please answer the following, if applicable:

Date of most recent colonoscopy: ____

Date of most recent mammogram: ____

Number of pregnancies: _____________ Number of live births: ____________ Age of first delivery: ____________

Age of first menstrual period: _________

Surgical History

Please list any previous surgeries you have had. Include year in which surgery was performed.

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Social History

Please circle the appropriate response.

Marital Status	Single	Married	Divorced	Widowed
Use of Alcohol	Never	Rarely	Moderate	Daily
Use of Tobacco	Never	Previously, but quit	Current	(Number of packs per day ________________________)
Use of Drugs	Never	Previously, but quit	Current	(Type and frequency ____________________________)

Occupation ____

Family History

	Age	Medical Conditions	If deceased, cause of death
Mother			
Father			
Grandparents			
Siblings			
Children			

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REVIEW OF SYMPTOMS
Please place a check mark next to the signs or symptoms you have been experiencing recently.

CONSTITUTIONAL
Activity Changes ____
Appetite Changes ____
Chills ____
Diaphoresis (Sweats) ____
Fatigue ____
Fever ____
Weight Changes ____

HEAD, EARS, NOSE, THROAT
Congestion ____
Dental Problems ____
Drooling ____
Ear Discharge ____
Ear Pain ____
Facial Swelling ____
Hearing Loss ____
Mouth Sores ____
Nosebleeds ____
Postnasal Drip ____
Runny Nose ____
Sinus Pressure ____
Sneezing ____
Sore Throat ____
Tinnitus (Ear Ringing) ____

EYES
Eye Discharge ____
Eye Itching ____
Eye Pain ____
Eye Redness ____
Photophobia (Light Sensitivity) ____
Visual Disturbances ____

RESPIRATORY
Apnea (Snoring) ____
Chest Tightness ____
Choking ____
Cough ____
Shortness of Breath ____
Stridor ____
Wheezing ____

CARDIOVASCULAR
Chest Pain ____
Leg Swelling ____
Palpitations ____

GASTROINTESTINAL
Abdominal Distention ____
Abdominal Pain ____
Anal Bleeding ____
Blood in Stool ____
Constipation ____
Diarrhea ____
Nausea ____
Rectal Pain ____
Vomiting ____

ENDOCRINE
Cold Intolerance ____
Heat Intolerance ____
Increased Thirst ____
Increased Hunger ____
Increased Urination ____

GENITOURINARY
Difficulty Urinating ____
Painful Intercourse ____
Painful Urination ____
Involuntary Urination ____
Flank Pain ____
Frequent Urine ____
Genital Sore ____
Hematuria (Blood in Urine) ____
Menstrual Problems ____
Urinary Urgency ____
Urine Decreased ____
Vaginal Bleeding ____
Vaginal Discharge ____
Vaginal Pain ____

MUSCULOSKELETAL
Arthralgias (Joint Pain) ____
Back Pain ____
Gait Problems ____
Joint Swelling ____
Myalgias (Muscle Pain) ____
Neck Pain ____
Neck Stiffness ____

SKIN
Color Changes ____
Pallor (Pale) ____
Rash ____
Wound ____

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ALLERGY/IMMUNOLOGY

Environmental Allergies ____
Food Allergies ____
Immunocompromised ____

NEUROLOGICAL

Dizziness ____
Facial Asymmetry ____
Headaches ____
Lightheadedness ____
Numbness ____
Seizures ____
Speech Difficulty ____
Syncope (Fainting) ____
Tremors ____
Weakness ____

HEMATOLOGIC

Adenopathy (Enlarged lymph gland) ____
Bruise, Bleed Easily ____

PSYCHIATRIC

Agitation ____
Behavioral Problems ____
Confusion ____
Decreased Concentration ____
Dysphoric Mood (Sad) ____
Hallucinations ____
Hyperactive ____
Nervous/Anxious ____
Self-Injury ____
Sleep Disturbance ____
Suicidal Ideas ____

For office use only:

Reviewed by: ____ Date: ___________________________