PLEASE COMPLETE EACH SECTION
PATIENT HISTORY FORM

Today's Date: _____

Name: _____ Date of Birth: _____

FAMILY HISTORY: _____ Heart Disease, _____ Stroke, _____Hypertension, _____Diabetes Mellitus, _____Cancer, _____Other
Who? (Example: Mother, Father, Sister, & Brother):_____

PATIENT HISTORY (Please place a check below for any past or ongoing medical problems). _____ NONE OF BELOW

_____Allergies/ Sinus Problems
_____AIDS/HIV
_____Anemia
_____Anxiety
_____Arthritis
_____Asthma/COPD
_____Back Problems
_____Broken Bones
_____ Cancer
_____Circulation Problems
_____Colon Polyps
_____Crohns/Ulcerative Colitis
_____Depression
_____Diabetes
_____Diverticulitis
_____Emphysema/COPD
_____Epilepsy/Seizures
_____Fibromyalgia
_____Ear Problems
_____GERD (Reflux)
_____Hiatal Hernia
_____Headaches
_____Hearing
_____Heart Problems
_____Hepatitis
_____Hernia
_____High Blood Pressure
_____Irritable bowel/Spastic Colon
_____Kidney Problem
_____Muscular Disease
_____Pancreatitis
_____Phlebitis/Blood clot
_____Psychiatric Problem
_____ Paralysis
_____ Pneumonia
_____ Prostate Problem
_____ Skin Rash or Eczema
_____ Stomach Ulcer
_____ Stroke/TIA
_____ Thyroid Problems
_____ Tuberculosis
_____ Urinary Tract Infection
_____ Venereal disease (STD)
_____ Visual or Eye Problem
_____ Other _____

DATE OF LAST:

Colonoscopy when: _____ Flu Shot When: _____ Prostate Exam When: _____
Chest X-ray when: _____ EKG When: _____ Pneumonia Shot When: _____
Tetanus Shot when: _____ Pap Smear When: _____ Mammogram When: _____

REVIEW OF SYSTEMS:

Please place check below by any symptom or condition you are experiencing *now* or in the past few days:

_____Fatigue, Excessive
_____Fever
_____Eye or Ear pain
_____Chest pains, pressure or tightness
_____Palpitations (heart fluttering)
_____Shortness of breath
_____Frequent coughing
_____Wheezing
_____Abdominal pain
_____Blood in stool or black stool
_____Nausea or vomiting
_____Diarrhea / Constipation
_____Neck pain or stiffness
_____Burning w/urination or frequency
_____Blood in urine
_____Difficulty swallowing
_____Leg cramps when walking
_____Swelling of hands or feet
_____Joint pains
_____Back Pain
_____Headache
_____Dizziness
_____Fainting or passing out
_____Weakness in arm or leg
_____Depression or anxiety
_____Pregnancy
_____Heartburn
_____ Other _____

Ever used tobacco (smoke, chew, dip)?
Yes_____ No _____
How much? _____
Date quit? _____

Ever used alcohol (wine, beer, liquor)?
Yes_____ No_____
How often?_____

Current or past abuse of drugs?
Yes_____ No_____
Type of Drug?_____

Type of Occupation (job)?_____
_____

Operations or surgeries: _____
Recent Hospitalizations (past 3 years): _____

(All information is treated as confidential unless you grant permission to release it)

Created 05/15/2012/la