PATIENT HISTORY FORM

Name:_____

Gender: ❍ M ❍ F **Age:**_____ **Date of Appointment:**_____

Reason for Visit

What brings you to the office today?_____

How is your general health? ❍ Excellent ❍ Good ❍ Fair ❍ Poor

Comprehensive Medical History

This important information is confidential. No one other than your healthcare provider will have access to or knowledge of this information without you express written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allows us to provide you the most complete medical care possible. This form will be reviewed with you during your visit.

Current Medications

What medications are you currently taking?
Please list any prescription medications, over the counter medication, vitamins, herbs or nutrition supplement that you are now taking. Please include the dosage amount and the times a day you take them.

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following? ❍ Adhesive Tape ❍ Antibiotics ❍ Aspirin ❍ Barbiturates *(for sleep)* ❍ Codeine ❍ Iodine ❍ Latex ❍ Local Anesthetics ❍ Sulfa

Do you have any other allergies?

Name	Reaction

Past Medical History *(check all that apply)*

- ❍ Alcoholism
- ❍ Allergies
- ❍ Anemia
- ❍ Anxiety Disorder
- ❍ Arthritis
- ❍ Artrial Fibrillation
- ❍ Asthma
- ❍ AIDS/HIV
- ❍ Back Problems
- ❍ Bleeding Disorder
- ❍ Blood Disease
- ❍ Blood Transfusion
- ❍ Bowel Disease
- ❍ Cancer
- ❍ COPD
- ❍ Coronary Artery Disease
- ❍ Depression
- ❍ Diabetes
- ❍ Ear Problems
- ❍ Eating Disorder
- ❍ Epilepsy
- ❍ Gerd *(reflux)*
- ❍ Glaucoma
- ❍ Gout
- ❍ Heart Disease
- ❍ Hearing Loss
- ❍ Heart Problems
- ❍ Hepatitis – A, B, or C
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ HIV/AIDS
- ❍ Hives
- ❍ Joint Disorder
- ❍ Kidney Disorder
- ❍ Leukemia
- ❍ Liver Disorder
- ❍ Lung Disease
- ❍ Lymphoma
- ❍ Measles
- ❍ Migraines
- ❍ Osteoporosis
- ❍ Pneumonia
- ❍ Polio
- ❍ Radiation Treatment
- ❍ Renal Disease
- ❍ Rheumatic Fever
- ❍ Stroke
- ❍ Seizures
- ❍ Skin Disorder
- ❍ Stomach Ulcer
- ❍ Substance Abuse
- ❍ Thyroid Disorder
- ❍ Tuberculosis
- ❍ Venereal Disease

Check-In By:_____

PATIENT HISTORY FORM *cont.*

Name:_____

Gender: ❍ M ❍ F **Age:**_____ **Date of Appointment:**_____

Hospitalizations & Surgeries

Reason	**Date**

Family History *(check all that apply)*

- ❍ Alcoholism
- ❍ Allergies
- ❍ Alzheimer's
- ❍ Anemia
- ❍ Anxiety
- ❍ Arthritis
- ❍ Asthma
- ❍ AIDS/HIV
- ❍ Bleeding Disorder
- ❍ Blood Disease
- ❍ Cancer
- ❍ Diabetes
- ❍ Depression
- ❍ Epilepsy
- ❍ Genetic Disorder
- ❍ Glaucoma
- ❍ Heart Disease
- ❍ Hepatitis – A, B, or C
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Joint Disorder
- ❍ Kidney Disease
- ❍ Liver Disorder
- ❍ Lung Disease
- ❍ Migraines
- ❍ Psychiatric Disorders
- ❍ Osteoporosis
- ❍ Stroke
- ❍ Substance Abuse
- ❍ Thyroid Disorder

Lifestyle Factors

Are you sexually active? ❍ Yes ❍ No # of partners in past year:_____

Do you wish to be checked for STDs? ❍ Yes ❍ No

Has anyone in your home ever physically or verbally hurt you? ❍ Yes ❍ No

Have you ever smoked? ❍ Yes ❍ No # of years:_____ # packs/day:_____

Do you smoke now? ❍ Yes ❍ No # packs/day:_____

Do you use recreational drugs? ❍ Yes ❍ No Types?_____ # times/week:_____

How much alcohol do you drink per week? ❍ Yes ❍ No # drinks/week:_____

How much caffeine do you drink per day? ❍ Yes ❍ No # drinks/day:_____

How often do you exercise? ❍ Yes ❍ No # times/week:_____

OBGYN History

Have you ever had, or do you currently have any of the following? *(check all that apply)*

- ❍ Abnormal Vaginal Bleeding
- ❍ Abnormal Pap Smear
- ❍ Bleeding between Periods
- ❍ Breast Lump
- ❍ Breast Cancer
- ❍ Breast Surgery
- ❍ Cervical Cancer
- ❍ Chlamydia
- ❍ Colonoscopy
- ❍ Cryosurgery
- ❍ DES Exposure
- ❍ Extreme Menstrual Pain
- ❍ Fibroids
- ❍ Genital Warts
- ❍ Gonorrhea
- ❍ Herpes
- ❍ Hot Flashes
- ❍ HPV
- ❍ Infertility
- ❍ Irregular Periods/Discharge
- ❍ Ovarian Cancer
- ❍ Ovarian Cysts
- ❍ Painful Intercourse
- ❍ Pelvic Inflammatory Disease
- ❍ Uterine Cancer
- ❍ Urinary Incontinence
- ❍ Yeast Infections - Frequent

Check-In By:_____

PATIENT HISTORY FORM *cont.*

Name:_____

Gender: ❍ M ❍ F Age:_____ Date of Appointment:_____

Pregnancy History

Please describe any pregnancies you have had:_____

# of Pregnancies:_____ # of Full Term:_____ # of Miscarriages:_____ # of Abortions:_____

Past Pregnancies

Date	Length of Pregnancy	Type of Delivery	Sex	Living

Were there any complications associated with any of your pregnancies?_____

Are you currently pregnant? ❍ Yes ❍ No

Are you trying to become pregnant? ❍ Yes ❍ No

Do you need birth control or contraceptive advice? ❍ Yes ❍ No

Menstrual History

When was the first day of your last period?_____

How often does your period occur?_____

How long does your periods last?_____

Is your period regular? ❍ Yes ❍ No

What age were you when you had you first period?_____

What age were you at menopause?_____

Check-In By:_____

PATIENT HISTORY FORM *cont.*

Name:_____

Gender: ❍ M ❍ F **Age:**_____ **Date of Appointment:**_____

Health Exams & Procedures *(Please check and date all immunizations you have had)*

	Mo/Yr	Result
❍ Blood Sugar-Fasting	___/___	_____
❍ Breast Self-Exam	___/___	_____
❍ Cholesterol Test	___/___	_____
❍ Colonoscopy	___/___	_____
❍ CT/CAT Scan	___/___	_____
❍ Dexascan *(Bone Density)*	___/___	_____
❍ EKG	___/___	_____
❍ Echocardiogram	___/___	_____
❍ Fecal Occult Blood Test	___/___	_____
❍ Mammogram	___/___	_____
❍ MRI	___/___	_____
❍ Pap Smear	___/___	_____

	Mo/Yr	Result
❍ Physcial Exam	___/___	_____
❍ Cardiac Stress Test	___/___	_____
❍ Ultrasound	___/___	_____
❍ Tetanus (Td) with Pretussis (Tdap)	___/___	_____
❍ Varicella *(Chicken Pox shot or disease)*	___/___	_____
❍ Pneumovax *(Pneumonia)*	___/___	_____
❍ Hepatitis A	___/___	_____
❍ Hepatitis B	___/___	_____
❍ MMR	___/___	_____
❍ Menigis	___/___	_____
❍ HPV	___/___	_____

Review of Symptoms *(check all that apply)*

ENT
❍ Bleeding Gums
❍ Blurred Vision
❍ Crossed Eyes
❍ Difficulty Swallowing
❍ Double Vision
❍ Earaches
❍ Ear Discharge
❍ Hay Fever
❍ Hoarseness
❍ Hearing Loss
❍ Nose-Bleeds
❍ Persistent Runny Nose
❍ Recurring Sore Throat
❍ Ringing in Ears
❍ Sinus Problems
❍ Vision Halos

Mental Health
❍ Anxiety
❍ Depression
❍ Loss of Interest
❍ Feeling Hopeless
❍ Hearing Voices
❍ Marital Problems
❍ Panic Attacks
❍ Trouble Concentrating
❍ Suicide *(Thoughts/Attempts)*

Gastrointestinal
❍ Appetite Gain
❍ Appetite Loss
❍ Bloating
❍ Bowel Changes
❍ Constipation
❍ Diarrhea
❍ Gas
❍ Hemorrhoids
❍ Indigestion
❍ Intestinal Disorder
❍ Lactose Intolerance
❍ Rectal Bleeding
❍ Stomach Pain
❍ Vomiting
❍ Vomittng Blood

Skin
❍ Acne
❍ Bruise Easily
❍ Changes in Moles
❍ Dry/Sensitive Skin
❍ Eczema
❍ Hives
❍ Itching
❍ Rash
❍ Scars
❍ Sores That Won't Heal

General
❍ Chills
❍ Dizziness
❍ Fainting
❍ Fever
❍ Hair Loss
❍ Hair Growth *(Excessive)*
❍ Night Sweats
❍ Sleeping Problems
❍ Thirst *(Excessive)*
❍ Weight Gain
❍ Weight Loss

Neurological
❍ Coordination Problems
❍ Convulsions
❍ Difficulty Walking
❍ Learning Disabilities
❍ Light-Headedness
❍ Memory Loss
❍ Numbness/Tingling
❍ Paralysis
❍ Seizures
❍ Speech Problems
❍ Tremors
❍ Other Symptoms:_____
_____
_____

Cardiovascular
❍ Chest Pains
❍ Irregular Heart Beat
❍ Circulation Problems
❍ Heart Palpitations
❍ Rapid Heartbeat
❍ Swelling of Ankles
❍ Varicose Veins

Respiratory
❍ Coughing
❍ Coughing Up Blood
❍ Shortness of Breath
❍ Wheezing

Genitourinary
❍ Blood Urine
❍ Lack of Bladder Control
❍ Frequent Urination
❍ Painful Urination

Race *(This information is needed for prenatal testing. Please feel free to ask your doctor any questions you may have regarding information gathered.)*

❍ American Indian or Alaska Native ❍ Native Hawaiian or Other Pacific Islander
❍ Black or African American ❍ White ❍ Asian ❍ Hispanic or Latino

Check-In By:_____