

**PATIENT HISTORY**

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ MR #: \_\_\_\_\_

TODAY'S DATE: \_\_\_/\_\_\_/\_\_\_

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

**PAST MEDICAL HISTORY**

MAJOR ILLNESS	YES (DATE)	NO	NOT SURE
AIDS			
ANEMIA			
ANXIETY			
ARTHRITIS			
ASTHMA			
AUTOIMMUNE DISEASE (LUPUS)			
BLEEDING DISORDERS			
BLOOD CLOTS IN LUNGS OR LEGS			
BLOOD TRANSFUSIONS			
BOWEL PROBLEMS			
BROKEN BONES			
CANCER			
CATARACTS			
CHICKENPOX			
CONVULSIONS / SEIZURES / EPILEPSY			
DES EXPOSURE			
DIABETES			
EATING DISORDERS			
FIBROIDS			

MAJOR ILLNESS	YES (DATE)	NO	NOT SURE
GALL BLADDER DISEASE			
GLAUCOMA			
HEADACHES			
HEART DISEASE			
HEPATITIS			
HIATAL HERNIA / REFLUX			
HIGH BLOOD PRESSURE			
INFERTILITY			
KIDNEY INFECTIONS			
KIDNEY STONES			
LIVER DISEASE			
LUNG DISEASE			
PNEUMONIA			
SEXUALLY TRANSMITTED DISEASE			
STROKE			
THYROID DISEASE			
TUBERCULOSIS			
ULCER			
OTHER			

**PAST SURGERIES**

NAME OF OPERATION	DATE

NAME OF OPERATION	DATE

**CURRENT MEDICATIONS**

(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	WHO PRESCRIBED

DRUG NAME	WHO PRESCRIBED

**ALLERGIES**

ALLERGY	TYPE OF REACTION

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**FAMILY HISTORY**

ILLNESS	YES	WHICH RELATIVE(S) (mother, father, grandmother, grandfather, sister, or brother)	AGE OF ONSET
ALCOHOL PROBLEMS			
ALZHEIMER'S DISEASE			
BIRTH DEFECTS			
BLOOD CLOTS IN LUNGS OR LEGS			
CANCER TYPE: _____			
DIABETES			
DRUG PROBLEMS			
HEART DISEASE			
HEPATITIS			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
HIV/AIDS			
MENTAL ILLNESS/DEPRESSION			
OSTEOPOROSIS (WEAK BONES)			
STROKE			
TUBERCULOSIS			
OTHER			

**PREGNANCY HISTORY**

TOTAL PREGNANCIES:	
TOTAL LIVE BIRTHS (Full Term):	
TOTAL MISCARRIAGES (Ab Spontaneous):	MISCARRIAGES OCCURRED IN ___1 <sup>ST</sup> ___2 <sup>ND</sup> ___3 <sup>RD</sup> TRIMESTER

**MENSTRUAL HISTORY**

AGE PERIODS BEGAN:
CYCLE INTERVAL: _____ DAYS
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING): _____ DAYS
FLOW: ___ LIGHT ___ MEDIUM ___ HEAVY
LAST NORMAL PERIOD (FIRST DAY): ___ / ___ / ___
HOME PREGNANCY TEST: ___ POSITIVE ___ NEGATIVE ___ TEST NOT DONE
MENOPAUSE STATUS: ___ PRE MENOPAUSAL ___ PERI MENOPAUSAL ___ POST MENOPAUSAL
AGE OF MENOPAUSE: _____ YEARS
PRESENT METHOD OF BIRTH CONTROL:
DO YOU HAVE BREAKTHROUGH BLEEDING?
ARE YOU TAKING HORMONAL REPLACEMENT MEDICATIONS?

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**SOCIAL HISTORY**

	NEVER	CURRENT	FORMER	AGE STARTED	AGE STOPPED	AMOUNT USED/DAY
<b>SUBSTANCE USE</b>						
ALCOHOL						
CAFFEINE						
COCAINE						
INHALANTS						
IV DRUG ABUSE						
MARIJUANA						
NARCOTICS						
OTHER SUBSTANCE ABUSE						
STIMULANTS						
TOBACCO						

<b>OCCUPATION</b>
<input type="checkbox"/> DESK JOB, MOSTLY
<input type="checkbox"/> HEALTH CARE PROFESSIONAL
<input type="checkbox"/> PHYSICAL JOB, MOSTLY

INFECTION RISK			INFECTION RISK		
	EXPOSED TO	POSSIBLY EXPOSED TO:		YES	NO
GENITAL HERPES			HISTORY OF BLOOD TRANSFUSION:		
GONORRHEA			HISTORY OF SEXUALLY TRANSMITTED DISEASE:		
HEPATITIS B			MULTIPLE SEXUAL PARTNERS:		
HIV			NEW SEXUAL PARTNER:		
SYPHILIS			NO KNOWN INFECTION RISK		
TUBERCULOSIS					

<b>EXERCISE</b>
<input type="checkbox"/> ACTIVE BUT NO FORMAL EXERCISE
<input type="checkbox"/> MINIMAL AMOUNT OF EXERCISE (ONCE PER WEEK OR LESS)
<input type="checkbox"/> MODERATE AMOUNT OF EXERCISE (1 - 3 TIMES PER WEEK)
<input type="checkbox"/> HEAVY AMOUNT OF EXERCISE (4 OR MORE TIMES PER WEEK)
<input type="checkbox"/> SEDENTARY

<b>DOMESTIC VIOLENCE</b>
<input type="checkbox"/> HISTORY OF EMOTIONAL ABUSE BY SPOUSE/PARTNER
<input type="checkbox"/> HISTORY OF PHYSICAL ABUSE BY SPOUSE/PARTNER
<input type="checkbox"/> REPORTED ABUSE TO LOCAL AUTHORITIES
<input type="checkbox"/> TRAUMA SECONDARY TO ABUSE
<input type="checkbox"/> TRAUMA SECONDARY TO ABUSE, WITH HOSPITALIZATION
<input type="checkbox"/> TRAUMA SECONDARY TO ABUSE, WITH SURGERY

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**REVIEW OF SYSTEMS**

Please check (x) if any of the following symptoms apply to you now or since adulthood

	NOW	PAST
<b>1. CONSTITUTIONAL</b>		
CHANGE IN HEIGHT		
FATIGUE		
FEVER		
WEIGHT GAIN		
WEIGHT LOSS		
<b>2. EYES</b>		
DOUBLE VISION		
SPOTS BEFORE EYES		
VISION CHANGES		
GLASSES/CONTACTS		
<b>3. EAR, NOSE, &amp; THROAT</b>		
EAR ACHES		
RINGING IN EARS		
HEARING PROBLEMS		
SINUS PROBLEMS		
SORE THROAT		
MOUTH SORES		
DENTAL PROBLEMS		
<b>4. CARDIOVASCULAR</b>		
CHEST PAIN OR PRESSURE		
DIFFICULTY BREATHING ON EXERTION		
SWELLING OF LEGS		
RAPID OR IRREGULAR HEARTBEAT		
<b>5. RESPIRATORY</b>		
PAINFUL BREATHING		
WHEEZING		
SPITTING UP BLOOD		
SHORTNESS OF BREATH		
CHRONIC COUGH		
<b>5. GASTROINTESTINAL</b>		
FREQUENT DIARRHEA		
BLOODY STOOL		
NAUSEA/VOMITING/INDIGESTION		
CONSTIPATION		
INVOLUNTARY LOSS OF GAS OR STOOL		
<b>7. GENITOURINARY</b>		
BLOOD IN URINE		
PAIN WITH URINATION		
STRONG URGENCY TO URINATE		
FREQUENT URINATION		
INCOMPLETE EMPTYING		
INVOLUNTARY/UNINTENDED URINE LOSS		
URINE LOSS WHEN COUGHING OR LIFTING		

	NOW	PAST
ABNORMAL BLEEDING		
PAINFUL PERIODS		
PREMENSTRUAL SYNDROME (PMS)		
PAINFUL INTERCOURSE		
ABNORMAL VAGINAL DISCHARGE		
<b>8. MUSCULOSKELETAL</b>		
MUSCLE WEAKNESS		
JOINT PAIN		
MUSCLE PAIN		
<b>9. SKIN</b>		
RASH		
SORES		
DRY SKIN		
MOLES (GROWTH OR CHANGES)		
<b>10. BREASTS</b>		
PAIN/TENDERNESS IN BREAST		
NIPPLE DISCHARGE		
LUMPS		
ABNORMAL CHANGE IN BREAST SIZE		
<b>11. NEUROLOGIC</b>		
DIZZINESS		
SEIZURES		
NUMBNESS OR TINGLING		
TROUBLE WALKING		
MEMORY PROBLEMS		
FREQUENT HEADACHES		
<b>12. PSYCHIATRIC</b>		
DEPRESSION OR FREQUENT CRYING		
ANXIETY		
<b>13. ENDOCRINE</b>		
HAIR LOSS		
HEAT INTOLERANCE		
COLD INTOLERANCE		
ABNORMAL THIRST		
HOT FLASHES		
<b>14. HEMATOLOGIC</b>		
FREQUENT BRUISES		
EASY BLEEDING		
ENLARGED LYMPH NODES (GLANDS)		
<b>15. ALLERGIC/IMMUNOLOGIC</b>		
SINUS ALLERGY SYMPTOMS		
ALLERGIC DERMATITIS		

FORM COMPLETED BY:  PATIENT  OFFICE MED ASST  OTHER  
 PATIENT SIGNATURE: \_\_\_\_\_