PATIENT HISTORY RECORD

NAME ____ DOB _______________
RACE _________________ ETHNICITY ________________

ALLERGIES ☐ None (please list allergies and what happens to you when you take it)
Drug Allergies: _________________________________ Food Allergies: ____________________________
_________________________________ ____________________________
_________________________________ Other Allergies:____________________________

CURRENT MEDICATIONS ☐ None ☐ Listed Below ☐ See copy of list attached
____ ____
____ ____
____ ____

PAST MEDICAL HISTORY: (please check all that apply)

☐ Allergies
☐ Anticoagulant Therapy
☐ Asthma
☐ Blood Clots
☐ Cancer, ______________
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ Diabetes, Type I or II
☐ Enlarged Prostate, Benign
☐ Fracture repair, _________
☐ Fibromyalgia
☐ Gall Stones, recurring
☐ GERD
☐ Headaches, migraine/tension
☐ Heart Attack
☐ Hemophilia, A or B
☐ High Cholesterol
☐ High Blood Pressure
☐ Iron Deficiency Anemia
☐ Irregular Heart Rhythm
☐ Kidney Stones
☐ Osteoarthritis
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Psychological Illnesses
☐ Rheumatoid Arthritis
☐ Stroke
☐ Thyroid Disease
☐ UTI, recurring
☐ Other: ________________
____
____

WOMEN'S HEALTH: Women Only (please check all that apply)

☐ Menopause, age at _____
☐ No. of pregnancies _____
☐ No. of births _____
☐ Last Mammogram _____
☐ Last Pap _____
☐ History of Abnormal Pap __________
☐ Birth Control Method _____
☐ Last Menstrual Period __________
☐ Age Onset _____

ADULT IMMUNIZATIONS: (check if you have had and fill in Last Given date)

☐ Influenza ___________
☐ HepA ______________
☐ Hep B ______________
☐ MMR _______________
☐ Pneumococcal _________
☐ Shingles ______________
☐ Tetanus __________
☐ Varicella _________
☐ Other ___________

PAST HOSPITALIZATIONS: (Please indicate date)

☐ Asthma
☐ Childbirth
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ DVT
☐ Diabetes
☐ Heart Attack
☐ Pneumonia
☐ Stroke
☐ Other: ________________
____

OTHER DOCTORS: (Please list all of your Physicians, optometrist, podiatrist, etc)
Primary Care Doctor: ____
Others (specialists): ____

ADVANCED DIRECTIVES: Do you have any of the following on file?
☐ Health Care Proxy ☐ Living Will ☐ Power of Attorney ☐ DNR

SURGICAL HISTORY: (Please indicate date & details)

- ☐ Appendectomy
- ☐ Arthroscopy, ____________
- ☐ Biopsy, ________________
- ☐ Carpal Tunnel Release
- ☐ Cataract Removal
- ☐ Circumcision
- ☐ C-section
- ☐ D & C
- ☐ Fracture Repair, _________
- ☐ Gall Bladder Removal
- ☐ Heart Surgery, __________
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint Replacement, _______
- ☐ Tubes in Ears
- ☐ Prostatectomy
- ☐ Rotator Cuff Repair
- ☐ Tonsil/Adenoidectomy
- ☐ Tubal Ligation
- ☐ Urinary Surgery, _________
- ☐ Vasectomy
- ☐ Other: _________________

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FAMILY HISTORY:
(Indicate which family member: M=mother; F=father; S=sibling; C=child; GM=grandmother; GF=grandfather)

- ☐ Alcoholism:
- ☐ Alzheimer's Disease:
- ☐ Asthma:
- ☐ Bleeding Tendency:
- ☐ Cancer, ________________
- ☐ Chemical Dependency:
- ☐ COPD:
- ☐ Coronary Artery Disease:
- ☐ Diabetes, Type I or II:
- ☐ Enlarged Prostate:
- ☐ Emphysema:
- ☐ Gall Stones, recurring:
- ☐ Heart Attack:
- ☐ Heart Disease:
- ☐ High Blood Pressure:
- ☐ High Cholesterol:
- ☐ Kidney Disease:
- ☐ Obesity:
- ☐ Osteoarthritis:
- ☐ Osteoporosis:
- ☐ Psychiatric Illness, _______
- ☐ Rheumatoid Arthritis:
- ☐ Seizure Disorder:
- ☐ Stroke:
- ☐ Thyroid Disease:
- ☐ Other: _________________

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SOCIAL HISTORY:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried Number of Children: ______
Occupation: ______________________________ Place of Employment: ______________________________
☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled
Hobbies and Activities: ____

TOBACCO/ALCOHOL/SUPPLEMENTS:
Do you use Tobacco? ☐ None ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco ☐ Other: ________________
How many? _____________ How often? _____________ How long have you used tobacco? _____________
Do you use Alcohol? ☐ None ☐ Beer ☐ Wine ☐ Liquor How much? _________ How often? _______
Caffeine intake: ☐ Coffee ☐ Tea ☐ Soda ☐ Chocolate How much? _________ How often? _________
Vitamin or Diet Supplements: Type: ____ How often? _________

SUBSTANCE ABUSE HISTORY:
☐ None Other: ____

MENTAL HEALTH HISTORY:
☐ None Other: ____

COMMUNICABLE DISEASE HISTORY:
☐ None Other: ____

ADDITIONAL COMMENTS, QUESTIONS, OR CONCERNS:

____

____

Date: __________________ Signature: ____