PATIENT HISTORY FORM

DATE: _______________

NAME: _______________________________________ EMAIL: ________________________________

ADDRESS: ____ZIP____________

HOME PHONE: _____________________________ CELL PHONE: ________________________

Alternate Contact: ____________________________________ Phone: __________________________

SOCIAL SECURITY NO. ___________________________ DATE OF BIRTH: _____________________

Briefly describe what brings you in today: ____

____

Are you allergic to any medications?

____

List Current Medications, Vitamins & Supplements: (need additional space, please list on a separate piece of paper)

Name of Medication	Dose	Number of times per day

Please check all medical history: *(write in other diagnoses if not listed)*

CARDIOVASCULAR		NEUROLOGY		RENAL	
Abnormal EKG		TIA (mini stroke)		Kidney infection (pyelonephritis)	
Congestive Heart Failure		Stroke		Kidney stones	
Heart Attack		Syncope		Chronic Kidney disease	
Heart Valve Disease or Endocarditis		Dementia			
Peripheral Vascular disease				**LIVER**	
Coronary Artery/Heart disease		**ENDOCRINE**		Cirrhosis	
Atrial Fibrillation		Diabetes		Elevated Liver Enzymes	
Deep Vein Thrombosis (DVT)		Elevated Cholesterol		Fatty Liver	
Pulmonary Embolism (PE)		Elevated Triglycerides		Hepatitis A, B, C	
Pacemaker		Low Thyroid (HYPO)			
Brand:		High Thyroid (HYPER)		**GASTROINTESTINAL**	
Date implanted:		Goiter		GERD	
Defibrillator				Gallbladder/Gallstones	
Brand:				Irritable Bowel Syndrome (IBS)	
Date implanted:				Ulcer	

Please complete back side →

Please check all medical history: (continued)

HEMATOLOGY		MUSCULOSKELETAL		HEAD & EYES	
Anemia		Arthritis (Osteo, Rheumatoid)		Migraines	
Platelet problems/Bleeding disorder		Fibromyalgia		Glaucoma	
		Gout		Cataracts	
		Lupus		Macular Degeneration	
PULMONARY					
Asthma					
Sleep Apnea		**ONCOLOGY**		**NOSE/SINUS**	
COPD		Cancer: (list type)		Infection/Sinusitis	
FEMALE GENITOURINARY				**PYSCHIATRIC**	
Endometriosis				Bipolar	
				Insomnia	
MALE GENITOURINARY					
Enlarged Prostate				**OTHER** (not listed)	
Elevated PSA					
Prostate cancer					
Radiation therapy for Prostate cancer					

List prior surgeries and or hospitalizations: (need additional space, please list on a separate piece of paper)

Date	Type of surgery/hospitalization	Physician	Hospital

Has any blood relative ever had: (Grandparents, parents, or children)	Please check one:		Which blood relative(s)?
	No	Yes	
Cancer			
Type of cancer:			
Type of cancer:			
Type of cancer:			
Diabetes			
High blood pressure			
Stroke			
Seizure(s)			
Pacemaker or Defibrillator			
Rheumatic/Scarlet Fever			
Heart Attack			
Heart Disease			
Bypass surgery			
Stents			
Heart Valve disease and/or replacement			

Do you have any advance directives (Living will, Power of attorney, Healthcare surrogate)? (circle one) YES NO

Occupation status: □ Current (line of work) ____________________ □ Retired (former line of work) ________________

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Re-Married Spouse's name ___________________

Number of children: ________ Hobbies: ____

Type of Exercise	**# of days per week**	**Consistent**	**Occasional**	**Rarely**

Do you use tobacco products? (circle one) Yes No Previously

Type of Tobacco product(s)	**Avg # of packs, cans, vials per day**	**How many years?**	**Past Avg # of packs, cans, vials per day**	**How many years?**	**Quit date**
Cigarettes					
Cigars					
Pipe					
Smokeless					
e-cigarette (vape)					

Do you drink alcoholic beverages? (circle one) YES or NO

Type of Alcohol	**Avg # of days per week**	**Avg # of drinks per sitting**	**Avg # of drinks per week**	
Beer				
Wine				
Liquor				
Mixed drinks				

Do you drink caffeinated beverages? (circle one) YES or NO

Type of caffeine	**Avg # of servings per day**
Coffee	
Tea	
Soda	
Energy drinks	
Chocolate	

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Who is your current PRIMARY CARE PHYSICIAN? ______________________________

Who may we thank for referring you to us? Physician ____________________ Patient _____________________

or Internet search (which site) ____________________________