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		CARDIOVASCULAR CON'T		NEUROLOGY	
Abnormal EKG		**Pacemaker**		TIA (mini stroke)	
Congestive Heart Failure		*Brand:*		Stroke	
Heart Attack		*Date implanted:*		Syncope	
Heart Valve Disease or Endocarditis		**Defibrillator**		Dementia	
Peripheral Vascular disease		*Brand:*			
Coronary Artery/Heart disease		*Date implanted:*		**RENAL**	
Deep Vein Thrombosis (DVT)				Kidney infection (pyelonephritis)	
Pulmonary Embolism (PE)				Kidney stones	
Blood Pressure:		**ENDOCRINE**		Chronic Kidney disease	
Hypertension		Diabetes			
Hypotension		Elevated Cholesterol		**LIVER**	
Arrhythmia: (list type)		Elevated Triglycerides		Cirrhosis	
		Low Thyroid (HYPO)		Elevated Liver Enzymes	
		High Thyroid (HYPER)		Fatty Liver	
		Goiter		Hepatitis A, B, C	

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		**ONCOLOGY**			
Sleep Apnea		Cancer: (list type)		**NOSE/SINUS**	
COPD				Infection/Sinusitis	
FEMALE GENITOURINARY				**PYSCHIATRIC**	
Endometriosis				Bipolar	
				Insomnia	
MALE GENITOURINARY				Depression	
Enlarged Prostate (*Benign*)		**GASTROINTESTINAL**			
Elevated PSA		GERD		**OTHER:** (not listed)	
Radiation therapy for Prostate cancer		Gallbladder/Gallstones		Anxiety	
		Irritable Bowel Syndrome (*IBS*)			
		Ulcer			

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: No	Yes	Which blood relative(s)?
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 such as a** *living will, medical power of attorney, or healthcare surrogate***?** (circle one) **YES** *or* **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 tobacco					
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	

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than one-half of the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Who is your current PRIMARY CARE PHYSICIAN? _____

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

or Internet search (which site) _____