PATIENT HISTORY

Name:_____

Date of Birth:_____ **Date of Visit:**_____

For all follow up visits please add any changes, INCLUDING medications, since your last visit. Each time, please complete the other side of this form. Thank you!

Describe briefly the reason for your visit to the doctor:

_____

_____

MEDICAL PROBLEMS and SURGICAL HISTORY:

Please List	Year
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

LIST THE DRUGS, VITAMINS & HERBS YOU'RE TAKING

Drug	Dose	Instructions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

HABITS:

Tobacco
- ❑ Never
- ❑ Current
- ❑ Former

_____
Packs/day

Marital Status
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widow/ Widower

Alcohol
- ❑ Never
- ❑ Social
- ❑ Former

Drugs (Recreational)
- ❑ Never
- ❑ Social
- ❑ Former

LIST ANY ALLERGIES:

1. _____
2. _____
3. _____
4. _____

Occupation: _____

Does any member of your family have a history of: **Colon cancer, stomach cancer, pancreatic cancer, esophageal cancer, breast cancer, ovarian cancer or uterine cancer, colonic polyps, Crohn's disease, ulcerative colitis, celiac disease or gallbladder disease?**

Circle the disease and list who (please specify): _____

_____

(OVER)

Name: _____

Review of Systems:

Circle all of your medical conditions. Circle all symptoms which have occurred in the past 6 months

Fever/ Chills Fatigue Weight loss/ Gain

Glasses Cataracts Glaucoma Poor Vision Retinopathy

Runny nose Stuffy Nose Hoarseness Dental problems
Difficulty swallowing Hearing Loss Dentures Sore throat

Previous heart attack Angina/chest pain Palpitations
Heart murmur Heart failure Swelling of feet
High blood pressure

Cough Sputum _____ Wheezing
Asthma/emphysema Shortness of breath Blood in sputum

Abdominal pain _____ Nausea/vomiting Diarrhea _____
Rectal bleeding Hemorrhoids Hernia
Constipation _____ Change in bowel habits Black stool
Stool incontinence Ulcers Gas/bloating
Heartburn Fecal urgency Rectal complaints

Blood in urine
History of kidney stones
Urinary incontinence
Urinate twice or more a night
Painful Urination

For women only

Age of first period _____
Date of last period _____
Number of pregnancies _____ # of birth _____
Abnormal bleeding
Painful periods – Date of last: _____
Painful intercourse
Hysterectomy
Date of last mammogram: _____
Date of last pap smear: _____
History of C-section: _____
History of forceps-assisted vaginal delivery_____

Weak urinary stream
History of prostatitis
History of prostate cancer

For men only

Skin cancer Itching/rashes Eczema Psoriasis

Joint pain/arthritis Gout Stiffness
Back pain Joint swelling

Seizure Numbness/ tingling Stroke/mini stroke Weakness
Blackouts Dizziness Headaches Tremor

Diabetes Thyroid disorder High Cholesterol Hormone replacement
Excessive thirst/ appetite

Anxiety Trouble sleeping Depression
Suicidal ideation Phobias Hallucinations

Anemia Bleeding disorder Easy bruising/ bleeding
History of blood transfusion Swollen glands

For Physician use only

Reviewed By: _____

Date: _____

_____

Sign your name