Patient History Form

Please complete the form prior to your appointment. Once completed either send to us via the Email or bring to your first appointment.

Full Name: Date of Birth:

Date:

Tell us about yourself:

Home situation (circle, or add in writing):

Single_____ Married (how long_____) Divorced (how long_____) Widowed (how long_____

) Domestic partnership____ Children _____ Are they healthy? _____

Employment:

Status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

Occupation:

type of work/jobs:_____

Habits:

Do you smoke?	No_____ Yes_____	If yes, how many packs per day?_____ If you have quit, how long ago?_____
Do you use other tobacco products?	No _____ Yes_____	If so, which products? _____
Do you use alcohol?	No_____ Yes_____	If yes, how often do you drink?_____ If you have quit, how long ago?_____ Do family or friends worry about your alcohol intake? _____
Do you use illicit drugs?	No_____ Yes_____	If yes, please specify _____

Nutrition Habits:

1. How would you describe your eating habits?

2. Would you like to increase or decrease your weight?

3. Are you on a special diet (diabetic, low fat, vegetarian, etc.?)

Exercise Habits:

1. Do you exercise on a regular basis? (3 or more times/week for 20-30 minutes or more)

2. What type of exercise do you do?

3. If you do not exercise is it due to a particular reason (physical limitations, job, family life, etc.?)

Psycho/Social:

1. Do you feel like your life has a purpose?

2. How would you describe your overall mood?

3. Are you or have you undergone any major issues/stresses in your life?

4. If yes, how do you cope with these issues or stressors?

Allergies or Adverse Drug Reactions:
Please list drug and type of reaction

Past Medical History:
Please list other diseases from which you <u>currently</u> suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the past:

Surgical History:
Please list any surgeries (operations), reason for the surgery, and the date of the surgery:

Medications:

Prescription medications	Dose	How often taken

Non-prescription /Supplements (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

Family History:
Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

Do you have Health Care Surrogate/Health Care Directives? (If yes, please provide a copy at your first visit)

Immunizations: if YES, give approximate year given

Pneumococcal No_____ Yes_____
Hepatitis A No_____ Yes_____
Hepatitis B No_____ Yes_____
Tetanus No_____ Yes_____
Shingles No_____ Yes_____
HPV Vaccine No_____ Yes_____

Safety:

Do you use seatbelts? No_____ Yes_____

Transfusions:

Have you ever received a blood transfusion? No_____ Yes_____ When?_____

Please mark any symptoms you are currently experiencing or have experienced in the last month:

SYMPTOM REVIEW

Gastrointestinal

- □ poor appetite
- □ abdominal pain
- □ indigestion
- □ trouble swallowing
- □ diarrhea
- □ constipation
- □ change in bowel habits
- □ nausea or vomiting
- □ rectal bleeding or blood in stools
- □ history of liver disease or abnormal liver tests

Cardiovascular

- □ chest pain
- □ history of angina or heart attack
- □ history of high blood pressure
- □ history of irregular beat
- □ history of poor circulation

Pulmonary/lungs

- □ shortness of breath
- □ persistent cough
- □ coughing up blood
- □ asthma or wheezing

Muscle/joint/bone

- □ swelling of ankles or legs pain, weakness or numbness in
- □ arms or hands
- □ back or hips
- □ legs or feet

General

- □ weight gain/loss of 10+ lbs during last 6 months
- □ poor sleep
- □ fever
- □ headache
- □ depression

Eyes, ears, nose, throat

- □ blurred vision
- □ other change in vision
- □ history of glaucoma or cataracts
- □ loss of hearing
- □ ringing in ears
- □ sinus problems
- □ hoarseness

Genitourinary

- □ frequent or painful urination
- □ blood in urine

Skin

- □ itching
- □ easy bruising
- □ change in moles

Endocrine

- □ history of diabetes
- □ history of thyroid disease
- □ change in tolerance to hot or cold weather
- □ excessive thirst

Women only

- □ abnormal Pap smear

□ neck or shoulders

Neurologic

□ history of stroke

□ blackouts or loss of consciousness

□ bleeding between periods

date of last mammogram_____

Men only

□ PSA

Anything else?

□ Are you experiencing an unusually stressful situation?

□ Are there any specific personal issues you would like to bring up at the time of your visit?

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT