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| --- | --- |
|  | **Patient History Form**  |
| **Name:**  |  | **Birth date:**  |
| **Marital Status:**  |  | **Occupation:**  |

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| **Allergies to Medications, Latex or Dyes □None □ Yes (please list)**  |
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| --- |
| **Medications (Prescriptions, non-prescriptions, vitamins and supplements) □None □ Yes (please list)**  |
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| --- |
| **Surgeries/Hospitalizations/Serious Injuries Year**  |
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|  |  |
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| --- |
| **Immunizations N Y N Y**  |
| **Hepatitis B Series**  |  |  |  | **Recent Pneumonia Vaccine**  |  |  |
| **Gardasil Series**  |  |  | **Recent Flu Vaccine**  |  |  |
| **Chicken Pox immunization or disease**  |  |  | **Positive TB Screening**  |  |  |

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| --- |
| **Health Maintenance No Yes (Year) No Yes (Year)**  |
| **Colonoscopy**  |  |  |  |  | **Bone Density**  |  |  |  |
| **Mammogram**  |  |  |  | **Eye Exam**  |  |  |  |
| **Pap Smear**  |  |  |  | **Physical Exam**  |  |  |  |

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| --- |
| **Social History No Yes**  |
| **Smoking**  |  |  |  **Pack(s)/day /years □ Quit**  |
| **Alcohol**  |  |  |  **Drinks/day drinks/week**  |
| **Caffeine**  |  |  |  **Drinks/day**  |
| **Recreational Drugs**  |  |  |  |
| **Special Diet**  |  |  | **If yes describe:**  |
| **Regular Exercise**  |  |  | **If yes describe:**  |
| **Sexually Active**  |  |  |  **□ Men □ Women □ Both**  |

|  |
| --- |
| **GYN History OB History**  |
| **Age of first mensus: ( ) Menopause □ N □ Y (if yes Age: )**  | **Total Number of Pregnancies: ( )**  |
| **Regular Periods □ N □ Y Painful Periods □ N □ Y**  |  **Full Term ( ) Pre Term ( )**  |
| **PMS □ N □ Y – if yes describe**  | **Miscarriages ( ) Abortions ( )**  |
| **Abnormal Pap: – if Yes approximate date ( )**  | **Tubal ( )**  |
| **Pain with intercourse: □ N □ Y Content with sex life: □N □ Y**  |
|  |

# Medical History (please check if positive)

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| --- | --- | --- |
| **ENT**  | **GENITOURINARY**  | **SKIN**  |
|  | **Eye Problems**  |  | **Urinary Infections**  |  | **Psoriasis**  |
|  | **Sinus Problems**  |  | **Kidney Disease/Stones**  |  | **Skin Disorders**  |
|  | **Hearing Loss**  |  | **Erectile Dysfunction**  |  | **Melanoma**  |
|  |  | **STD**  |  |  |
|  **CARDIOVASCULAR**  |  | **Urinary Incontinence**  |  |  |
|   | **Abnormal EKG**  | **MUSCULOSKELETAL**  | **PSYCH**  |
|  | **Chest Pain**  |  | **Arthritis/Osteo**  |  | **ADD/ADHD**  |
|  | **Heart Attack**  |  | **Arthritis/Rheumatoid**  |  | **Anxiety**  |
|  | **Heart Disease**  |  | **Gout**  |  | **Depression**  |
|  | **High Blood Pressure**  |  | **Neck/Spinal Problems**  |  | **Memory Loss**  |
|  | **High Cholesterol**  | **NEUROLOGICAL**  |  | **OCD**  |
|  | **Stroke**  |  | **Concussion**  |  | **Suicidal Thoughts/attempt**  |
|  | **Peripheral Vascular Disease**  |  | **Headaches**  |  |  |
| **PULMONARY**  |  | **Migraines**  |  |  |
|  | **Asthma**  |  | **Epilepsy/Seizures**  |  |  |
|  | **Emphysema/COPD**  | **HEMATOLOGICAL**  |  |  |
|  | **Shortness of Breath**  |  | **Anemia**  |  |  |
|  | **Sleep Apnea**  |  | **Bleeding Disorders**  |  |  |
| **GASTROINTESTINAL**  |  | **Blood Clots**  |  |  |
|  | **Acid Reflux**  |  | **Cancer**  |  |  |
|  | **Constipation**  |  | **Sickle Cell Disease**  |  |  |
|  | **Diarrhea**  | **ENDOCRINE**  |  |  |
|  | **Irritable Bowel**  |  | **Diabetes**  |  |  |
|  | **Gall Bladder Disease**  |  | **Thyroid Disease**  |  |  |
|  | **Hernia**  |  | **Pancreatitis**  |  |  |
|  | **Liver Disease**  |  |  |  |  |
|  |  |  |  |  |  |

# Family History (please check all applicable boxes)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Illness**  | **Father**  | **Mother**  | **Sibling**  | **Child**  | **Maternal** **G-mother**  | **Maternal** **G-father**  | **Paternal G-mother**  | **Paternal** **G-father**  | **Other**  |
| **Asthma**  |  |  |  |  |  |  |  |  |  |
| **Bleeding Disorders**  |  |  |  |  |  |  |  |  |  |
| **Breast Cancer**  |  |  |  |  |  |  |  |  |  |
| **Colon Cancer**  |  |  |  |  |  |  |  |  |  |
| **Depression/Anxiety**  |  |  |  |  |  |  |  |  |  |
| **Diabetes**  |  |  |  |  |  |  |  |  |  |
| **Drug/Alcohol Addiction**  |  |  |  |  |  |  |  |  |  |
| **Heart Disease**  |  |  |  |  |  |  |  |  |  |
| **High Blood Pressure**  |  |  |  |  |  |  |  |  |  |
| **High Cholesterol**  |  |  |  |  |  |  |  |  |  |
| **Kidney Disease**  |  |  |  |  |  |  |  |  |  |
| **Leukemia**  |  |  |  |  |  |  |  |  |  |
| **Liver Disease**  |  |  |  |  |  |  |  |  |  |
| **Lung Cancer**  |  |  |  |  |  |  |  |  |  |
| **Osteoporosis**  |  |  |  |  |  |  |  |  |  |
| **Ovarian Cancer**  |  |  |  |  |  |  |  |  |  |
| **Pancreatic Cancer**  |  |  |  |  |  |  |  |  |  |
| **Rheumatoid Arthritis**  |  |  |  |  |  |  |  |  |  |
| **Stroke**  |  |  |  |  |  |  |  |  |  |
| **Thyroid Disease**  |  |  |  |  |  |  |  |  |  |
| **Other:**  |  |  |  |  |  |  |  |  |  |

 **Forms created courtesy of Atlas MD**