PATIENT HISTORY FORM

DATE TODAY:_____

WE STRIVE TO KEEP ALL INFORMATION IN CONFIDENCE AND WILL NOT RELEASE WITHOUT SIGNED CONSENT. It may be sent to consultants, if referred.

NAME:_____ Birth date:_____ AGE:_____
LAST FIRST M.I.

MARITAL STATUS: ( ) SINGLE; ( ) MARRIED; ( ) WIDOWED; ( ) SEPARATED; ( ) DIVORCED

OCCUPATION:_____

REASON FOR VISIT TODAY:_____
LAST MEDICAL EXAM:_____ **LAST DOCTOR:**_____
LAST CHEST X-RAY (Date and location):_____

ALLERGIES (DRUGS, X-RAY DYE, TAPE, LATEX) **& type of reaction**:_____

PHARMACY NAME & PHONE #:_____

MEDICATIONS: (LIST ALL MEDICATIONS, INCLUDING THOSE NOT PRESCRIBED, SUCH AS ALTERNATIVE AGENTS OR HERBAL AGENTS).

DRUG	STRENGTH	HOW OFTEN YOU TAKE PER DAY	LENGTH OF TIME YOU HAVE TAKEN
i.e.: Advil	200 mg	3 times per day	6 months

Please know what drugs and doses you take; if you need refills let the nurse know when she places you in the exam room.

CHILDHOOD ILLNESSES: Chicken Pox ( ) Measles/Rubeola ( ) Mumps ( ) Rubella ( ) Scarlet fever ( )

PREVIOUS MEDICAL ILLNESS/HOSPITALIZATION (other than under surgery):_____

***If Diabetic**, do you self-test with glucose meter?_____ Do you get yearly eye exams?_____ Have you been to a self- management course?_____ Do you know what to do for low blood sugar?_____ Foot care?_____ HgbA1C current value?_____

SURGERY: (IF YES, PLEASE CHECK ( ) AND GIVE APPROXIMATE DATE IN BLANK SPACE)

( )Appendectomy_____ ( )C-Section_____ ( )Hernia repair_____
( )Breast Biopsy_____ ( )Gallbladder_____ ( )Hysterectomy_____ ( )Ovary: R_____ L_____
( )Carotid artery_____ ( )Heart angioplasty_____ ( )Mastectomy_____ ( )Stomach surgery_____
( )Cataracts_____ ( )Heart bypass_____ ( )Prostate removal_____ ( )Tonsillectomy_____

OB/GYN History: Pregnancies: #_____ Deliveries: #_____ Last menstrual cycle:_____

****Check _X_ if YES, or write "NO" in front of the items below:**

_____Tobacco use # of packs per day:_____ # of years:_____
Are you interested in stopping? Yes_____ No_____
_____Tobacco use in past When did you stop?_____
If you continue to smoke, exercise regularly! When ready to stop, call if you want help
_____Alcohol use Beer_____ Wine_____ Liquor_____ ounces/glasses/cans per week on average):_____

***** Do not mix drinking and driving please. *****

_____Caffeine use Coffee:_____ cups per day Sodas:_____ cans/ounces per day:

_____Exercise Type:_____ Times per week:_____
*** Goal of 30 minutes of walking-type exercise 5 days per week recommended. ***

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FAMILY HISTORY: Place an "X" in the space next to the condition that your family member has, then specify their relation to you after the condition, using the following abbreviations:

Mother (M); Father (F); Brother (B); Sister (S); Grandparent (GP); Aunt (A); Uncle (U)

For example, if your Aunt and Mother had breast cancer: (X) Breast Cancer A, M

( ) Alcoholism_____	( ) Colon Polyps_____	( ) High Blood Pressure_____	( ) Prostate cancer___
( ) Anemia_____	( ) Colon cancer_____	( ) Iron Disease_____	( ) Seizures_____
( ) Asthma_____	( ) Diabetes_____	( ) Kidney Disease_____	( ) Thyroid disease__
( ) Arthritis_____	( ) Glaucoma_____	( ) Mental Illness_____	( ) Tuberculosis____
( ) Bleed easily_____	( ) Gout_____	( ) Migraine_____	
( ) Breast Cancer_____	( ) Heart Disease_____	( )Osteoporosis_____	

	LIVING	AGE ORAGEATDEATH.	Present health or cause of death
FATHER	( ) Yes ( ) No	_____	_____
MOTHER	( ) Yes ( ) No	_____	_____
SIBLING	( ) Yes ( ) No	_____	_____
SIBLING	( ) Yes ( ) No	_____	_____

Immunizations: (Please check the disease against which you have been immunized and date of last booster.) **Tetanus or Td booster is due every 10 years**. Let the nurse know if you are due for a booster.

( ) Hepatitis B	( ) Tetanus	( ) Measles/Mumps/Rubella
( ) Pneumonia_____	( )Heapatitis A_____	( ) D.T. (Diphtheria/Tetanus)
( ) Varicella_____	( )Flu Vaccine	( ) Meningitis vaccine

***If you have Hepatitis C or chronic liver disease, talk to your doctor about keeping up to date with your shots. You may benefit from Hepatitis A or B vaccine, or even the Pneumonia shot.

***If you have lung disease, keep up to date with the Influenza and Pneumonia shots.

Illicit Drugs Use? Please discuss with your physician.

Risk factors for AIDS & Hepatitis B and C are the following. If any apply, please let your physician know during your visit. We will observe confidentiality.

Blood transfusion; homosexual relations; IV drug use; relations with IV drug user; needle sticks; work with body fluids, such as dental work, nursing, ER, etc.; sex with multiple partners.

Mark with an "X" if YES or write "NO", for the following items.

_____ **Diet:** Are you interested in information on diets for weight or cholesterol or diabetes?

_____ **Calcium intake:** Do you know women need about 1000mg of calcium intake per day?

_____ **Bone Density tests:** check if interested in information; considered after age 50 in women.

_____ **Colon exams:** Did you know most experts recommend a colon exam every 5 years, after age 50? Please let us know if you have a family history of colon cancer.

_____ **Mammography:** recommended yearly in women after age 40; check if due for this test.

Safety Measures: Examples of action you can take are: Seat belts (every time), bicycle helmets (even adults), wrist protection during roller-blading, eye protection (weed-eating, power sawing, etc.), proper gun use (locking, unloading, keeping out of children's access).

Advanced Directives: Please discuss with your spouse or family and your physician.

Living Will: No ( ) Yes( ) Organ Donor: No ( ) Yes ( )

Durable Power of Attorney for Health Care: No ( ) Yes ( ) Who is your POA for Health Care?_____

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PLEASE PLACE A "**Y**" BY THE CURRENT COMPLAINT OR ALIMENT THAT APPLIES TO YOU, IF UNSURE, PLACE A QUESTION MARK "?", IF IT DOES NOT APPLY, PLACE AN " **N**".

HEAD
_____BLURRED VISION
_____LAST EYE EXAM DATE
_____GLAUCOMA
_____FREQUENT HEADACHES
_____MIGRAINE HEADACHES
_____LUMPS OR SWELLING IN NECK
_____CONSTANT RINGING IN EARS
_____HEARING PROBLEMS
_____FREQUENT EARACHES
_____FREQUENT NOSEBLEEDS
_____SINUS INFECTION
_____ALLERGIES/HAYFEVER
_____HOARSE VOICE, PERSISTENT
_____MOUTH OR TONGUE SORES

LUNGS
_____ASTHMA
_____HAVE COUGHED UP BLOOD
_____INCREASING SHORTNESS OF BREATH WITH ACTIVITY
_____EMPHYSEMA
_____HISTORY OF TUBERCULOSIS
_____CHRONIC COUGH

HEART
_____FREQUENT IRREGULAR HEARTBEAT
_____CHEST PAIN OR TIGHTNESS IN CHEST
_____HEART MURMUR_____Mitral valve prob.
_____HISTORY OF ENLARGED HEART
_____SHORTNESS OF BREATH AT NIGHT
_____SWELLING OF FEET, ANKLES PRESENT AFTER SLEEP
_____HISTORY RHEUMATIC FEVER
_____HIGH BLOOD PRESSURE
_____PREVIOUS HEART ATTACK

ABDOMEN
____FREQUENT HEARTBURN
_____DIFFICULTY OR PAIN IN SWALLOWING
_____HAVE VOMITED BLOOD
_____RECTAL PAIN OR BLEEDING (BLACK OR BLOODY)
_____RECENT CHANGE IN BOWEL HABITS
_____DIVERTICULITIS or DIVERTICULOSIS
_____COLON POLYPS
_____Last Colon exam date:_____
_____HEPATITIS/YELLOW JAUNDICE/ LIVER DISEASE
_____NAUSEA
_____CONSTIPATION
_____DIARRHEA; how often per day_____
_____ABDOMINAL PAIN WITH Fatty Food
_____SUSPECT ULCERS
_____HEMORRHOIDS
_____HISTORY OF ULCERS
_____BLEEDING

NEURO
_____LOSS OF APPETITE
_____SEIZURE
_____LOSS OF CONSIOUSNESS
_____DOUBLE VISION
_____MEMORY LOSS
_____NUMBNESS OF HANDS OR FEET
_____NERVOUSNESS AFFECTING HOME LIFE OR WORK
_____SPEECH PROBLEMS
_____STROKE

KIDNEY
____RECURRENT URINARY TRACT INFECTION
_____URINATION AT NIGHT MORE THAN ONCE
_____BROWN, BLACK OR BLOODY URINE
_____BURNING ON URINATION
_____KIDNEY STONES
_____DIFFICULTY STARTING STREAM
_____PROBLEMS WITH SEXUAL FUNCTION
_____URINARY INCONTINENCE

JOINTS
____BACK TROUBLE
_____SWOLLEN JOINTS
_____FREQUENT PAINFUL FEET
_____FREQUENT SHOULDER PAIN
_____FREQUENT OR PERSISTENT ACHING OF MUSCLES OR JOINTS
_____GOUT
_____ARTHRITIS
_____OSTEOPOROSIS-How diagnosed?

GENERAL
____DIABETES: Date diagnosed: _____
_____WEIGHT LOSS GREATER THAN 10 LBS IN LAST YR
_____LOSS OF INTEREST IN EATING
_____SLEEPING DIFFICULTY
_____HERPES IN PAST-genital or face
_____THYROID PROBLEMS
_____BLOOD PRESSURE PROBLEMS
_____MOLE OR SORE NOT HEALING
_____HOT OR COLD NATURED
_____SUSPECT SERIOUS DISEASE OR CANCER
_____LEG CRAMPS WHILE WALKING
_____MORE THIRSTY LATELY
_____FATIGUE
_____FREQUENT CRYING SPELLS, DEPRESSION
_____WORK OR FAMILY PROBLEMS
_____ANXIETY
_____ANEMIA
_____HIGH CHOLESTEROL & last result_____

MALES ONLY
_____WEAK URINE STREAM
_____PAINFUL ORSORE GENITALS (PRIVATES)
_____PROSTATE TROUBLE
_____HARD TO EMPTY BLADDER COMPLETELY
_____PERFORM SELF TESTICLE EXAM MONTHLY
_____LAST PSA TEST (if over age 50). DATE_____

FEMALES ONLY
____LAST MENSTRUAL PERIOD_____
____VAGINAL DISCHARGE OR PROBLEMS
_____PAINFUL ORSORE GENITALS (PRIVATES)
_____LUMPS OR PAIN IN BREASTS
_____IF YOU SEE A GYNECOLOGIST, LIST NAME _____
_____**Last Bone Density Test** Date _____
_____**LAST MAMMOGRAPHY** Date_____
_____**LAST PAP SMEAR** Date_____
_____PERFORM SELF BREAST EXAM MONTHLY