FOR OFFICE USE ONLY

INS: _________________ APPT:___________________

REF:______________________

PATIENT HISTORY

(version: 102407)

Last Name:____First__________________
Age: _____ Date of birth: ____/____/____

Main Reason for today's visit: ____
Referred to our office by:____

PAST MEDICAL HISTORY:
Have you ever been diagnosed or treated for any of the following:

__Asthma
__Arthritis
__Congestive Heart Failure
__Depression
__Diabetes
__Emphysema / COPD
__Heart Attack
__High Blood Pressure
__High Cholesterol
__Thyroid problems
__Reflux / acid indigestion
__Other:__________________

Please list any hospitalizations or surgeries (date, reason, hospital)
____
____

FAMILY HISTORY:
(Please circle one and list health problems)

Family Member	Alive / Deceased		Age	Health problems
Mother	A	D		
Father	A	D		
Sister / Brother	A	D		
Sister / Brother	A	D		
Sister / Brother	A	D		
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		

SOCIAL HISTORY
Occupation:____
Do you smoke? ___ No, I've never smoked
___ Yes, I've smoked ____ packs per day for ____ years.
___ I use smokeless tobacco.
___ Quit ________ ago.

Do you drink? No____ Yes, _____socially _____daily
Do you eat a heart healthy diet? ___Yes ___No ___Sometimes
Do you exercise? ___Yes, ___times a week. ___No
Type of exercise____

Have you had a physical exam within the last 12 months? _____Yes _____No
On average, how many hours do you sleep each night? __________
If age 50 or over, have you had a colonoscopy? _____Yes _____No Normal____ Abnormal____

FEMALE PATIENTS Have you had a pap smear within the last year? _____Yes _____No

If you are over 40, have you had a mammogram within the past year? _____Yes _____No

TODAY'S SYMPTOMS:

ONLY circle **YES** if you are having any symptoms listed below **TODAY**:

GENERAL

Fever	Yes	No
Weight loss	Yes	No
Appetite loss	Yes	No

SKIN

Rash	Yes	No
Change in a mole	Yes	No

EYES, EARS, NOSE, THROAT

Blurred vision	Yes	No
Ear pain	Yes	No
Hearing loss	Yes	No
Ringing in ears	Yes	No
Balance problem	Yes	No
Nasal congestion	Yes	No
Sinus pain	Yes	No
Sore throat	Yes	No

NECK

Neck pain	Yes	No
Neck stiffness	Yes	No
Swollen glands	Yes	No

RESPIRATORY

Cough	Yes	No
Sputum Production	Yes	No
Shortness of breath	Yes	No
Wheezing	Yes	No

BREAST

Breast mass or pain	Yes	No
Nipple discharge	Yes	No

CARDIOVASCULAR

Chest pain	Yes	No
Irregular pulse	Yes	No
Leg swelling	Yes	No

GASTROINTESTINAL

Nausea	Yes	No
Vomiting	Yes	No
Abdominal pain	Yes	No
Indigestion / Reflux	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Blood in stool or vomit	Yes	No
Black stools	Yes	No

MUSCULOSKELETAL

Back pain	Yes	No
Joint pain or swelling	Yes	No
Arm or leg weakness	Yes	No

NEUROLOGICAL

Headaches	Yes	No
Memory problems	Yes	No
Coordination problems	Yes	No
Feel faint	Yes	No

PSYCHIATRIC

Anxiety	Yes	No
Depression	Yes	No
Insomnia	Yes	No
Bipolar	Yes	No

ENDOCRINE

Always thirsty	Yes	No
Urinate frequently	Yes	No

HEMATOLOGIC

Bruise easily	Yes	No
Have had blood transfusion	Yes	No

GENITOURINARY

Cannot hold urine	Yes	No
Painful urination	Yes	No
Blood in urine	Yes	No
Impotence	Yes	No

ALLEGIES TO MEDICATIONS: _____Yes _____No

If yes, please list: ____

____ ________________

Patient Signature Date