



ESTABLISHED PATIENT HISTORY

Name: _____ SSN# _____ -- -- DOB: _____ Date: _____

Referring Doctor: _____ Family Doctor: _____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

What improves or worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous or does it come and go? _____

Describe the pain (sharp/dull, etc.) _____

Have you tried any medicine/treatment for this problem/pain? _____

Doctor's Note:

SURGICAL HISTORY

Please list any recent surgeries you have had and date of surgery:

SOCIAL HISTORY

Please provide the following information:

Marital Status:

Single Married Separated Divorced Widowed Life Partner Common Law Spouse

Occupation - Please CIRCLE the one that applies:

None Laborer Truck Driver Tradesman Clerk Administrative Executive Professional Part-Time Retired Other: _____

Alcohol Consumption:

_____ None _____ Yes Occasional / Social # of drinks per day _____

Tobacco per day:

_____ None _____ Yes # _____ Packs/day _____ Cigarettes/day _____ Smokeless Tobacco

If you previously stopped, when? _____

Recreational Drugs: _____ None If yes, please list: _____

Caffeinated beverages: _____ None _____ Low _____ Moderate _____ Excessive

ALLERGIES – Please list ALL types (Drug, seasonal, pets, environmental foods)

PHARMACY NAME: _____ PHONE #: _____

PHARMACY ADDRESS: _____ City: _____ State: _____ Zip: _____

CURRENT MEDICATIONS – Please list ALL medications you are currently taking including over the counter medicine:

Drug Name:	Strength:	Directions/How you take it:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Attach medication list if necessary

CURRENT REVIEW OF SYSTEMS:

Please mark (X) if you have any of the following:

CONSTITUTIONAL:

- Appetite changes
- Anorexia
- Aches/Pains
- Chills
- Easily bruises
- Fever
- Fatigue
- Generalized Weakness
- Insomnia
- Night Sweats
- Oriented
- Swollen Glands
- Weight Gain
- Weight Loss
- Other: _____

EYES:

- Blind
- Blurred Vision
- Cataracts
- Decreased Vision
- Double Vision
- Glaucoma
- Eye Pain
- Other: _____

ALLERGIC/ IMMUNOLOGIC:

- Animal Allergies
- Drug Allergies
- Environmental Allergies
- Food Allergies
- Hayfever Allergies
- Seasonal Allergies
- Other: _____

NEUROLOGICAL:

- Balance problems
- Disoriented
- Dizzy spells
- Headache
- Lack of Alertness
- Leg or Arm Weakness
- Memory Loss
- Numbness/ Tingling
- Stroke

- Speech Problems
- Tremors
- Other: _____

ENDOCRINE:

- Diabetes
- Excess thirst
- Pituitary Disease
- Thyroid Disease
- Tired/ Sluggish
- Too hot/cold
- Other: _____

GASTROINTESTINAL:

- Abdominal Cramps
- Abdominal Pain
- Acid Reflux
- Bloody Stools
- Change in Bowel Habits
- Constipation
- Diarrhea
- Flatulence
- Gas
- Hemorrhoids
- Indigestion/Heartburn
- Nausea/ Vomiting
- Rectal Bleeding
- Tarry Stools
- Other: _____

CARDIOVASCULAR:

- Arrhythmia
- Chest pain/ Angina
- Dyspnea on exertion
- Edema
- Hardening of the arteries
- Heart Attack
- Heart Failure
- Heart Murmur
- High Blood Pressure
- Irregular Heart beat
- Low exercise tolerance
- Mitral Valve Prolapse
- Orthopnea
- Pace Maker Implant
- Pain/cramps w/exercise
- Palpitations

- Skipped Heart beats
- Swelling
- Other: _____

INTEGUMENTARY/ SKIN:

- Acne
- Boils
- Changing moles
- Persistent Itch
- Pigment changes
- Skin rash
- Other: _____

MUSCULOSKELETAL:

- Arthritis
- Back Pains
- Gout
- Joint Pains
- Muscle Cramps
- Muscle Weakness
- Neck Pain/ Stiffness
- Other: _____

EARS/ NOSE/ THROAT:

- Ear Infection
- Sinus Problems
- Sore Throat
- Other: _____

GENITOURINARY:

- Back Pain
- Bedwetting
- Blood in urine
- Dribbling
- Burning on Urination
- Erection Problems
- Flank Pain
- Hesitancy
- Kidney Failure
- Kidney Infections
- Kidney Stones
- Nocturia
- Nocturnal Enuresis
- Painful Ejaculations
- Stranguria
- Suprapubic Pain

- Testes/Scrotal Swelling
- Urgency
- Urinary Frequency
- Urinary Hesitancy
- Urinary Incontinence
- Urinary Tract Infections
- Urine Retention
- Urologic Cancer
- Urologic Surgery
- Varicose Veins Scrotum
- Weak Stream

- Prostate Infection
- Sexual Dysfunction
- Vaginal Bleeding
- Vaginal Discharge/Problem
- Other: _____

RESPIRATORY:

- Asthma
- Emphysema/Bronchitis
- Environmental Allergies
- Frequent Cough
- Pneumonia
- Shortness of Breath
- Tuberculosis
- Wheezing
- Other: _____

HEMATOLOGICAL/LYMPHATIC:

- Swollen Glands
- Blood Clotting Problems
- Bleeding Problems
- Hepatitis
- HIV/ AIDS
- Sickle Cell
- Other: _____

PSYCHOLOGICAL:

- Anxious
- Depressed
- Generally satisfied with life
- Other: _____

Patient Signature: _____

Date: _____

Print Name: _____