



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:

PAST MEDICAL HISTORY

Please mark (X) if you have or have had any of the following diseases or conditions:

CARDIOVASCULAR:

- ___ Anemia
- ___ Angina
- ___ Anorexia
- ___ Aortic Aneurysm
- ___ Aortic Insufficiency
- ___ Aortic Stenosis
- ___ Arrhythmia
- ___ Atrial fibrillation
- ___ Bleeding Disorder
- ___ Cerebrovascular Disease
- ___ Congenital Heart Disease
- ___ Congestive Heart Failure
- ___ Deep Vein Thrombosis
- ___ Enlarged Heart
- ___ Heart Attack
- ___ Heart Disease
- ___ Heart Murmur
- ___ Heart Valve Problem
- ___ Hemophilia
- ___ Hypertension
- ___ Leukemia
- ___ Mitral Insufficiency
- ___ Mitral Stenosis
- ___ Rheumatic Fever
- ___ Sickle Cell Anemia
- ___ Stroke
- ___ Other: _____

ENDOCRINE/ METABOLIC:

- ___ Diabetes Mellitus--
(non- insulin dependent)
- ___ Diabetes Mellitus--
(insulin dependent)
- ___ Diabetes Mellitus--
(uncontrolled)
- ___ Goiter
- ___ Gout
- ___ Hyperthyroidism
- ___ Hypothyroidism
- ___ Impaired Glucose
Tolerance
- ___ Other: _____

GENERAL:

- ___ Allergies
- ___ Hepatitis _____
- ___ High Cholesterol
- ___ Infectious Disease
- ___ Lipid disorder
- ___ Malaise
- ___ Obesity
- ___ Phlebitis
- ___ Sleep Apnea
- ___ Other: _____

GASTROINTESTINAL:

- ___ Cholecystitis
- ___ Cholelithiasis
- ___ Chronic Liver Disease
- ___ Colitis
- ___ Constipation
- ___ Colon Condition
- ___ Crohn's Disease
- ___ Diarrhea
- ___ Diverticulitis
- ___ Diverticulosis
- ___ GERD
- ___ Hemorrhoids
- ___ Hiatal Hernia
- ___ Inflammatory Bowel
Disease
- ___ Liver Disease
- ___ Pancreatitis
- ___ Peptic Ulcer
- ___ Rectal Fissure
- ___ Stomach Ulcer
- ___ Other: _____

GENITOURINARY:

- ___ Acute Prostatitis
- ___ AIDS
- ___ Benign Prostatic
Hypertrophy
- ___ Bladder Infection
- ___ Chronic Prostatitis
- ___ Chronic Renal Insufficiency

- ___ Chronic Renal Failure
- ___ Elevated PSA
- ___ Epididymitis
- ___ HIV
- ___ HPV
- ___ Interstitial Cystitis
- ___ Kidney Disease
- ___ Kidney Infection
- ___ Kidney Stones
- ___ Penile Discharge
- ___ Prostate Cancer
- ___ Undescended Testicle
- ___ Urinary Tract Infection
- ___ Venereal Disease

- ___ Bladder Cancer
- ___ Erectile Dysfunction
- ___ Infertility
- ___ Pre-mature ejaculation
- ___ Testicular Cancer
- ___ Other: _____

HEENT:

- ___ Blindness
- ___ Cataracts
- ___ Deafness
- ___ Ear Infections
- ___ Glaucoma
- ___ Hay Fever
- ___ Mumps
- ___ Vertigo
- ___ Other: _____

MUSCULOSKELETAL:

- ___ Arthritis
- ___ Back Pain
- ___ Carpal Tunnel Syndrome
- ___ Fibromyalgia
- ___ Other: _____

NEUROLOGICAL/ PSYCHOLOGICAL

- ___ ADD

- ___ ADHD
- ___ Alcoholism
- ___ Alzheimer's Disease
- ___ Anxiety Disorder
- ___ Bi-Polar
- ___ Chronic Fatigue Syndrome
- ___ Depression
- ___ Eating Disorder
- ___ Epilepsy
- ___ Herniated Disc
- ___ Mental Illness
- ___ Migraine
- ___ Nervous Breakdown
- ___ Parkinson's Disease
- ___ Polio
- ___ Stroke
- ___ Suicide Attempt
- ___ Other: _____

RESPIRATORY

- ___ Asthma
- ___ Bronchitis
- ___ Chronic Lung Disease
- ___ COPD
- ___ Emphysema
- ___ Pulmonary Embolism
- ___ Tuberculosis
- ___ Other: _____

TUMORS:

- ___ Brain Tumors
- ___ Breast Cancer
- ___ Cervical Cancer
- ___ Colon Cancer
- ___ Gastric Cancer
- ___ Laryngeal Cancer
- ___ Lung Cancer
- ___ Lymphoma
- ___ Melanoma
- ___ Pancreatic Cancer
- ___ Rectal Cancer
- ___ Other: _____

SURGICAL HISTORY

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

FAMILY HISTORY

Please mark (X) if a parent, sibling, aunt, uncle and/or grandparent has/had any of the following.:

Mark (X) if applies	Condition:	Relationship to you:
	Arthritis	
	Bedwetting	
	Bladder Cancer	
	Cancer:	
	Crohn's Disease	
	Depression	
	Diabetes	
	Gout	
	Heart Attack	
	Hypertension	
	Kidney Disease, <i>Please specify:</i>	
	Kidney Stones	
	Leukemia	
	Malignant Melanoma	
	Multiple Sclerosis	
	Laryngeal Cancer	
	Pancreatic Cancer	
	Prostate Cancer	
	Stroke	
	Thyroid Disease	
	Tuberculosis	
	Other:	

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)

Print Name _____

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

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: _____