

**PATIENT HISTORY FORM-CONFIDENTIAL**

Name \_\_\_\_\_ Date \_\_\_\_\_

Primary physician/Family doctor \_\_\_\_\_

**Past Medical History** (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Stomach ulcers                |
| <input type="checkbox"/> Heart attack/angina          | <input type="checkbox"/> Diabetes                      |
| <input type="checkbox"/> Congestive heart failure     | <input type="checkbox"/> Cancer (specify) _____        |
| <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Asthma                        |
| <input type="checkbox"/> Lung disease(specify) _____  | <input type="checkbox"/> Kidney disease(specify) _____ |
| <input type="checkbox"/> Liver disease(specify) _____ | <input type="checkbox"/> Other _____                   |

Do you have Hepatitis B/Hepatitis C/Tuberculosis or HIV infection? (Circle any that apply)

Previous Surgeries	Treating Facility/Physician	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medical condition**

- Cancer
- Heart disease
- Diabetes
- Stroke/circulation problems
- Asthma
- Gout
- Other \_\_\_\_\_

**Who in family has/had this?** (circle all that apply)

- |        |        |        |         |     |          |
|--------|--------|--------|---------|-----|----------|
| father | mother | sister | brother | son | daughter |
| father | mother | sister | brother | son | daughter |
| father | mother | sister | brother | son | daughter |
| father | mother | sister | brother | son | daughter |
| father | mother | sister | brother | son | daughter |
| father | mother | sister | brother | son | daughter |

**Please indicate if you use the following substances**

- |                    |          |           |                         |
|--------------------|----------|-----------|-------------------------|
| Tobacco            | __ Never | __ rarely | __ Daily (amount) _____ |
| Alcohol            | __ Never | __ rarely | __ Daily (amount) _____ |
| Recreational drugs | __ Never | __ rarely | __ Daily (amount) _____ |

What medications do you take? *(Please list each medication and dosage)*


*I do not take any medications*

Do you have any known medication allergies? *(Please list medication and reaction)*


*I do not have any known medication allergies*

**REVIEW OF SYSTEMS**

Please check if you have/had problems related to the areas indicated.

	YES	NO		YES	NO
<b>1. CONSTITUTIONAL</b>			<b>7. ENDOCRINE SYSTEM</b>		
Weight change	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Hormone treatment	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Anabolic steroids	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. EYES</b>			<b>8. BREAST/GENITAL</b>		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Menopause	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>
Vision surgery	<input type="checkbox"/>	<input type="checkbox"/>	Genital infections	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. EARS, NOSE, THROAT</b>			<b>9. URINARY SYSTEM</b>		
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract/bladder infections	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Gum bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Trouble urinating	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. RESPIRATORY</b>			Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<b>10. SKIN</b>		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancers	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<b>11. NEUROLOGIC</b>		
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. CARDIOVASCULAR</b>			Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>	Nerve damage	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<b>12. PSYCHIATRIC</b>		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis or blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<b>13. MUSCULOSKELETAL</b>		
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. GASTROINTESTINAL</b>			Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<b>OTHER</b> _____		
Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Diarrhea/constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Hernia/repair	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		

The information provided in this form is true and complete to the best of my knowledge.

Patient signature \_\_\_\_\_

Updated (date) \_\_\_\_\_

Form reviewed by physician: \_\_\_\_\_

Date: \_\_\_\_\_