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|  |  |  |
| --- | --- | --- |
|  | **Patient History Form** | |
| **Name:** |  | **Birth date:** |
| **Marital Status:** |  | **Occupation:** |

|  |  |
| --- | --- |
| **Allergies to Medications, Latex or Dyes □None □ Yes (please list)** | |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| **Medications (Prescriptions, non-prescriptions, vitamins and supplements) □None □ Yes (please list)** | |
|  |  |
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| --- | --- |
| **Surgeries/Hospitalizations/Serious Injuries Year** | |
|  |  |
|  |  |
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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Immunizations N Y N Y** | | | | | | |
| **Hepatitis B Series** |  |  |  | **Recent Pneumonia Vaccine** |  |  |
| **Gardasil Series** |  |  | **Recent Flu Vaccine** |  |  |
| **Chicken Pox immunization or disease** |  |  | **Positive TB Screening** |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health Maintenance No Yes (Year) No Yes (Year)** | | | | | | | | |
| **Colonoscopy** |  |  |  |  | **Bone Density** |  |  |  |
| **Mammogram** |  |  |  | **Eye Exam** |  |  |  |
| **Pap Smear** |  |  |  | **Physical Exam** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Social History No Yes** | | | |
| **Smoking** |  |  | **Pack(s)/day /years □ Quit** |
| **Alcohol** |  |  | **Drinks/day drinks/week** |
| **Caffeine** |  |  | **Drinks/day** |
| **Recreational Drugs** |  |  |  |
| **Special Diet** |  |  | **If yes describe:** |
| **Regular Exercise** |  |  | **If yes describe:** |
| **Sexually Active** |  |  | **□ Men □ Women □ Both** |

|  |  |
| --- | --- |
| **GYN History OB History** | |
| **Age of first mensus: ( ) Menopause □ N □ Y (if yes Age: )** | **Total Number of Pregnancies: ( )** |
| **Regular Periods □ N □ Y Painful Periods □ N □ Y** | **Full Term ( ) Pre Term ( )** |
| **PMS □ N □ Y – if yes describe** | **Miscarriages ( ) Abortions ( )** |
| **Abnormal Pap: – if Yes approximate date ( )** | **Tubal ( )** |
| **Pain with intercourse: □ N □ Y Content with sex life: □N □ Y** | |
|  | |

# Medical History (please check if positive)

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| --- | --- | --- | --- | --- | --- |
| **ENT** | | **GENITOURINARY** | | **SKIN** | |
|  | **Eye Problems** |  | **Urinary Infections** |  | **Psoriasis** |
|  | **Sinus Problems** |  | **Kidney Disease/Stones** |  | **Skin Disorders** |
|  | **Hearing Loss** |  | **Erectile Dysfunction** |  | **Melanoma** |
|  | |  | **STD** |  |  |
| **CARDIOVASCULAR** | |  | **Urinary Incontinence** |  |  |
|  | **Abnormal EKG** | **MUSCULOSKELETAL** | | **PSYCH** | |
|  | **Chest Pain** |  | **Arthritis/Osteo** |  | **ADD/ADHD** |
|  | **Heart Attack** |  | **Arthritis/Rheumatoid** |  | **Anxiety** |
|  | **Heart Disease** |  | **Gout** |  | **Depression** |
|  | **High Blood Pressure** |  | **Neck/Spinal Problems** |  | **Memory Loss** |
|  | **High Cholesterol** | **NEUROLOGICAL** | |  | **OCD** |
|  | **Stroke** |  | **Concussion** |  | **Suicidal Thoughts/attempt** |
|  | **Peripheral Vascular Disease** |  | **Headaches** |  |  |
| **PULMONARY** | |  | **Migraines** |  |  |
|  | **Asthma** |  | **Epilepsy/Seizures** |  |  |
|  | **Emphysema/COPD** | **HEMATOLOGICAL** | |  |  |
|  | **Shortness of Breath** |  | **Anemia** |  |  |
|  | **Sleep Apnea** |  | **Bleeding Disorders** |  |  |
| **GASTROINTESTINAL** | |  | **Blood Clots** |  |  |
|  | **Acid Reflux** |  | **Cancer** |  |  |
|  | **Constipation** |  | **Sickle Cell Disease** |  |  |
|  | **Diarrhea** | **ENDOCRINE** | |  |  |
|  | **Irritable Bowel** |  | **Diabetes** |  |  |
|  | **Gall Bladder Disease** |  | **Thyroid Disease** |  |  |
|  | **Hernia** |  | **Pancreatitis** |  |  |
|  | **Liver Disease** |  |  |  |  |
|  |  |  |  |  |  |

# Family History (please check all applicable boxes)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Illness** | **Father** | **Mother** | **Sibling** | **Child** | **Maternal**  **G-mother** | **Maternal**  **G-father** | **Paternal G-mother** | **Paternal**  **G-father** | **Other** |
| **Asthma** |  |  |  |  |  |  |  |  |  |
| **Bleeding Disorders** |  |  |  |  |  |  |  |  |  |
| **Breast Cancer** |  |  |  |  |  |  |  |  |  |
| **Colon Cancer** |  |  |  |  |  |  |  |  |  |
| **Depression/Anxiety** |  |  |  |  |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |  |  |  |  |
| **Drug/Alcohol Addiction** |  |  |  |  |  |  |  |  |  |
| **Heart Disease** |  |  |  |  |  |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |  |  |  |  |  |
| **High Cholesterol** |  |  |  |  |  |  |  |  |  |
| **Kidney Disease** |  |  |  |  |  |  |  |  |  |
| **Leukemia** |  |  |  |  |  |  |  |  |  |
| **Liver Disease** |  |  |  |  |  |  |  |  |  |
| **Lung Cancer** |  |  |  |  |  |  |  |  |  |
| **Osteoporosis** |  |  |  |  |  |  |  |  |  |
| **Ovarian Cancer** |  |  |  |  |  |  |  |  |  |
| **Pancreatic Cancer** |  |  |  |  |  |  |  |  |  |
| **Rheumatoid Arthritis** |  |  |  |  |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |  |  |  |  |
| **Thyroid Disease** |  |  |  |  |  |  |  |  |  |
| **Other:** |  |  |  |  |  |  |  |  |  |

**Forms created courtesy of Atlas MD**