PATIENT HISTORY FORM

Patient Name: ___________________________________ Date of Birth_____________________________

Today's Date_____________________________________ Social Security Number_____________________

PAST MEDICAL HISTORY

Previous Physician's name:__________________________ Date of last exam:__________________________

Have you ever been hospitalized? Yes____ No_____ If yes, what for?______________________________

Have you ever been tested for hepatitis A, B or C? Yes____ No______ Which Hepatitis virus?____________

Vaccines: **Hepatitis B:** Yes___ No___ If yes, date:____________ **Influenza:** Yes___ No___ If yes, date:____________

Tetanus: Yes___ No___ If yes, date:_____________**Pneumonia:** Yes___ No___ If yes, date:____________

Have you had a sexually transmitted disease? Yes_____ No_____ Diagnosis________________________

Which of the following conditions are you currently being treated or have been treated for in the past?

Heart disease/Murmur/Angina___ Shortness of breath___ Eye Disorder/glaucoma___ Diabetes_____

High cholesterol_____ Asthma_____ Seizures_____ Kidney/Bladder problems_____

High blood pressure_____ Lung problems/cough_____ Stroke_____ Liver problems/Hepatitis____

Low blood pressure_____ Sinus problems_____ Neurological problems_____ Cancer______

Anemia or blood problems_____ Tonsillitis_____ Depression/Anxiety______ Ulcers/colitis______

Swollen ankles_______ Ear problems_______ Psychiatric care______ Thyroid problems________

Please describe any current or past medical treatment not listed above:

____

____

Please list your past surgeries:

____

____

Allergies

Are you allergic to penicillin or any other drugs? Yes _________ No ____________

Please list :____ reaction: _________________________________

Medications:

Please list: ____

____

PLEASE COMPLETE REVERSE SIDE

Family History

	Living	Age	List serious illnesses
Father:	Yes___ No___	______	______________________________
Mother:	Yes___ No___	______	______________________________
Sisters :	Yes___ No___	______	______________________________
	Yes___ No___	______	______________________________
	Yes___ No___	______	______________________________
Brothers:	Yes___ No___	______	______________________________
	Yes___ No___	______	______________________________
	Yes___ No___	______	______________________________

Has any member of your family (including children and parents) had any of the following illnesses?

Illness	Which family member? (Mother or father's side?)	
Anemia or blood disease	______________________________	**Living Yes _____No_____**
Cancer (which kind?)	______________________________	**Living Yes _____No_____**
Diabetes	______________________________	**Living Yes _____No_____**
Glaucoma	______________________________	**Living Yes _____No_____**
Heart disease	______________________________	**Living Yes _____No_____**
High blood pressure	______________________________	**Living Yes _____No_____**
HIV disease/ AIDS	______________________________	**Living Yes _____No_____**
Mental Illness/ Depression	______________________________	**Living Yes _____No_____**
Stroke	______________________________	**Living Yes _____No_____**
Other serious illness	______________________________	**Living Yes _____No_____**

Social and Preventative History:

Do you drink alcohol, beer, or wine? Yes ___ No ___ if no, have you in the past? Yes _____ No _____

How many drinks per week? ___________

Do you currently drink coffee and/or tea? Yes ___ No ___ If yes, how many cups per day? ______________

Do you exercise daily/weekly? Yes ___ No ___

Do you currently smoke or chew tobacco? Yes____No ___ if no, have you in the past? Yes_____ No ______

Do you wear seatbelts while driving? Yes __ No __ Do you wear a helmet while riding a bike? Yes ___ No ____

Females: Gynecological History:

How many times have you been pregnant? ____________ How many children do you have ________________

Date of last Pap Smear? _______________ Have you ever had an abnormal Pap Smear? Yes___ No___

Diagnosis: ___________ Follow up: ____________________________

Date of last Mammogram? ______________________ Mammogram results? ____________________________

Have you ever had a breast biopsy? Yes ___ No ___ Biopsy results: __________________________________

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature ____Date: ____________