Patient History

Name: _____ Date of Birth: _____

Family History:

(F: father, M: mother, PGF/MGF: Paternal/Maternal Grandfather, PU/PA: Pat. Uncle/Aunt, etc.)

Alcoholism: F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
Breast Cancer: F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
Congestive Heart Failure: F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
Colon Cancer: F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
Coronary Artery Disease: F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
CVA/TIA (Stroke): F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
Diabetes: F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
Hypercholesterolemia: F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
Hypertension: F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
MI (Heart Attack): F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
Prostate Cancer: F, PGF, MGF, PU, MU, Sibling, Child
Renal Lithiasis (Kidney Stones): F, M, PGF, MGF, PGM, MGM, Sibling, Child
Seizures: F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
Skin Cancer: F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
Tuberculosis: F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child
Other: _____ F, M, PGF, MGF, PGM, MGM, PU, PA, MU, MA, Sibling, Child

Social History:

(Please circle what applies and fill in blanks where appropriate.)

Marital Status: -Single- -Married- -Divorced- -Widowed- -Partnered-
Currently Live: -At Home- -In Assisted Living- -In Nursing Home-
-With ____ (#) of Children at Home-
Occupation: -Current- -Retired- -Disabled- -None-
: -Teacher- -Oil Field Worker- -Homemaker- -Other: _____.
Alcohol: -None- -Occasional- -Daily- -Quit: date _____.
: # of drinks ___ / -day- -week- -month- of -beer- -wine- -hard liquor- -combo-
Drug Abuse: -None- -Street drugs- -Prescription drugs- / -Current- -Past-
: Injectable (name/s) _____, Quit (date) _____ .

Past Medical History:

Last EKG: _____
Last Screening Lab Work: _____

Last Colonoscopy: _____

Women:

Last Pap Smear: _____
Last Mammography: _____
Last BMD (Bone Mineral Density) Screening: _____

(Check each that apply to you:)

_____ Anemia
_____ Anxiety
_____ Asthma: -acute- -chronic- -exercise induced-
_____ Cancer: -bladder- -blood- -bone- -brain- -breast- -colon- -liver-
-lung- -lymph- -ovarian- -pancreatic- -prostate- -skin- -thyroid-
-uterine- -other: _____ date/s: _____
_____ Congestive Heart Failure
_____ Coronary Artery Disease
_____ Dementia / Alzheimers
_____ Depression
_____ Diabetes: -type 1- -type 2-
_____ Glaucoma
_____ Gout
_____ Hypercholesterolemia
_____ Hypertension
_____ Hyperthyroidism
_____ Hypothyroidism
_____ Lupus
_____ Migraines
_____ Osteoarthritis
_____ **Pregnancy**: # _____, # _____of children. Miscarriage/Abortion/D&C_____ (#/#/#)
_____ Renal Lithiasis (Kidney Stones)
_____ Seizures
_____ Other: _____

Past Surgical History:

(Please fill in each blank with the APPROXIMATE YEAR when each surgery took place.)

Appendectomy: _____
Bladder Suspension: _____
Breast Augmentation: _____
CABG (Coronary Artery Bypass Graft): _____
Carotid Stent: _____
Cholecystectomy / Gallbladder (Laparoscopic / Abdominal): _____
Coronary Stent: _____

C-Section: _____
Hernia Repair: Inguinal (Right/Left) _____, Umbilical _____, Ventral _____
Hysterectomy: _____
-vaginal- -abdominal- / *Ovaries*: -removed- -retained-
Myringotomy Tubes: _____
Rotator Cuff Repair: _____ -right- -left- -both-
T&A (Tonsillectomy/Adenoidectomy): _____
Tonsillectomy: _____
Total Hip Replacement: _____ -right- -left- -both-
Total Knee Replacement: _____ -right- -left- -both-
Tubal Ligation: _____
Vasectomy: _____
Other: _____

Demographics:

Preferred Language: -English- -Spanish- -Other: _____.
Race: -White- -African American- -Native American- -Asian-
-Middle Eastern- -Other: _____
Ethnicity: -Hispanic- -Not Hispanic-
Communication Preference: -Home Phone- -Cell Phone- -Post Office/Mail-
Electronic Copy of Clinical Information: -yes- -no-
(Please see front desk for explanation.)
Smoking Status: -Current daily- -Current occasional- -Never- -Quit, date: _____
If current/past smoker: # packs per day _____? X # of years _____?
Pharmacy: _____ Town: _____

Specialists:

(Specialty: cardiology, dermatology, counseling, etc.)

Name: _____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Current Medications:

(Dosage)

Name: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies:

(Reaction to Med.)

_____ _____

_____ _____

_____ _____

_____ _____

Signature: _____ Date Completed: _____