

PATIENT HISTORY FORM

NAME:	BIRTH DATE:	MARITAL STATUS: S M W D SEP	DATE:
OCCUPATION:	BIRTH PLACE:	RELIGION:	EDUCATION: GRADE LEVEL _____ COLLEGE _____ POST GRAD _____

FAMILY HISTORY	IF A BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE.		
1) EPILEPSY	6) THYROID	11) OSTEOPOROSIS	16) ALCOHOLISM
2) MIGRAINE	7) HAYFEVER	12) ARTHRITIS	17) CANCER
3) MENTAL ILLNESS	8) ASTHMA	13) HEART DISEASE	18) PROBLEM WITH ANESTHESIA
4) GLAUCOMA	9) ANEMIA	14) STROKE	
5) DIABETES	10) BLEEDS EASILY	15) HYPERTENSION	

HOSPITAL ADMISSIONS	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
Not including pregnancies				

LIST ALL MEDICATIONS YOU ARE NOW TAKING	ALLERGIES	REACTION	VACCINE RECEIVED	Year of last	TEST/EXAM	Year of last
			TETANUS		SIGMOIDOSCOPY	
			FLU		PAP/PELVIC	
			PNEUMONIA		CHOLESTEROL	
			HEPATITIS		EYE	
			TUBERCULOSIS		MAMMOGRAM	

MEDICAL HISTORY Mark (C) for current problems. Check (✓) and indicate when you had any of the following symptoms or disease.

EARS - NOSE - THROAT	GASTROINTESTINAL	GENERAL	INFECTIONS
<input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Ringing in Ear <input type="checkbox"/> Ear Infections-frequent <input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Failing Vision/eye Pain <input type="checkbox"/> Double or Blurred Vision <input type="checkbox"/> Eye Infections-frequent <input type="checkbox"/> Nose Bleeds-frequent <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Sore Throats-frequent <input type="checkbox"/> Hayfever / Allergies <input type="checkbox"/> Hoarseness-prolonged	<input type="checkbox"/> Loss of Appetite-recent <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Indigestion/Heartburn <input type="checkbox"/> Persistent Nausea/Vomiting <input type="checkbox"/> Peptic Ulcers <input type="checkbox"/> Abdominal Pain-chronic <input type="checkbox"/> Gall Bladder Trouble <input type="checkbox"/> Jaundice / Hepatitis <input type="checkbox"/> Change in Bowel Habits <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Chrohn's / Colitis <input type="checkbox"/> Bloody or Tarry Stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Weight Loss-recent <input type="checkbox"/> Obesity	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Convulsions/Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremor/Hands Shaking <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Numbness/Tingling Sensations <input type="checkbox"/> Headaches/frequent <input type="checkbox"/> Migraines <input type="checkbox"/> Arthritis/Rheumatism <input type="checkbox"/> Back Pain-recurrent <input type="checkbox"/> Bone Fracture/Joint Injury <input type="checkbox"/> Problems walking/Falling <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Foot Pain <input type="checkbox"/> Cold Numb Feet <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Sleeping-difficulty <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Memory loss <input type="checkbox"/> Moodiness-excessive <input type="checkbox"/> Phobias <input type="checkbox"/> Mental illness <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Bleeding Problem	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes <input type="checkbox"/> Hiv/AIDS <input type="checkbox"/> Syphilis HABITS <input type="checkbox"/> Alcohol _____ oz per week <input type="checkbox"/> Smoking _____ cig. Per day _____ #yrs. <input type="checkbox"/> Coffee/tea _____ cups/day <input type="checkbox"/> Drug Addiction/Occasional Use FEMALES - Please complete <i>Menstrual flow:</i> <input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain/Cramps _____ Days of Flow _____ Days of Cycle Date-1st date of last period _____ <input type="checkbox"/> Pain/bleeding during/after sex <i>Number of:</i> _____ Pregnancies _____ Abortions _____ Miscarriages _____ Live births Birth Control Method _____ B.C. Pill (Name) _____ <input type="checkbox"/> Flushing/Menopause <input type="checkbox"/> Date of Last PAP Test _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Date of last Mammogram _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
LUNGS - HEART - CIRCULATION	GENITO URINARY		
<input type="checkbox"/> Pneumonia /Pleurisy <input type="checkbox"/> Bronchitis/Chronic Cough <input type="checkbox"/> Asthma/Wheezing Shortness of Breath: <input type="checkbox"/> On Exertion <input type="checkbox"/> Lying Flat <input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Attack <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Irregular Pulse / <input type="checkbox"/> Palpitations <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Leg Pain-when walking <input type="checkbox"/> Varicose Veins/Phlebitis	<input type="checkbox"/> Urine Infections-frequent <input type="checkbox"/> Blood in Urine Urination <input type="checkbox"/> Three times at Night <input type="checkbox"/> Painful <input type="checkbox"/> Loss of Control <input type="checkbox"/> Decrease in Force/Flow <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Urethral Discharge <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily		

SUMMARY:
