PATIENT HISTORY

Name:________________________________

Date of Birth:____________________ **Date of Visit:**________________

For all follow up visits please add any changes INCLUDING medications, since your last visit. Each time, please complete the other side of this form. Thank you!

Please briefly describe the reason for your visit:

____

____

MEDICAL PROBLEMS and SURGICAL HISTORY:

Please List	Year
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

LIST THE DRUGS, VITAMINS & HERBS YOU'RE TAKING

Drug Dose Instructions
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

HABITS:

Tobacco:
□Never
□Current
□Former
____
Packs/day

Alcohol:
□Never
□Social
□Former

Drugs (Recreational)
□Never
□Social
□Former

Marital Status:
□Single
□Married
□Divorced
□Widow/Widower

LIST ANY ALLERGIES

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Occupation: ______________________________

Does any member of your family have a history of: **Colon cancer, stomach cancer, pancreatic cancer, esophageal cancer, breast cancer, ovarian cancer or uterine cancer, colonic polyps, Crohn's disease, ulcerative colitis, celiac disease or gallbladder disease?**

Circle the disease and list who (please specify):

____

____

(TURN OVER)

Name: ___________________________________

Review of Systems:

Circle all of your medical conditions. Circle all symptoms which have occurred in the past 6 months

Fever/ Chills | Fatigue | Weight loss/ Gain

Glasses | Cataracts | Glaucoma | Poor Vision | Retinopathy

Runny nose | Stuffy Nose | Hoarseness | Dental problems
Difficulty swallowing | Hearing Loss | Dentures | Sore throat

Previous heart attack | Angina/chest pain | Palpitations
Heart murmur | Heart failure | Swelling of feet
High blood pressure

Cough | Sputum _________ | Wheezing
Asthma/emphysema | Shortness of breath | Blood in sputum

Abdominal pain _____________ | Nausea/vomiting | Diarrhea ____________
Rectal bleeding | Hemorrhoids | Hernia
Constipation ________ | Change in bowel habits | Black stool
Stool incontinence | Ulcers | Gas/bloating
Heartburn | Fecal urgency | Rectal complaints

Blood in urine
History of kidney stones
Urinary incontinence
Urinate twice or more a night
Painful Urination

For Men Only:

Weak urinary stream
History of prostatitis
History of prostate cancer

For Women Only:

Age of first period ____________
Date of last period ____________
Number of pregnancies ______ # of birth ______
Abnormal bleeding
Painful periods – Date of last: _______
Painful intercourse
Hysterectomy
Date of last mammogram: ____________
History of C-section: ________________________
Date of last pap smear: _______________
History of forceps-assisted vaginal delivery______

Skin cancer | Itching/rashes | Eczema | Psoriasis

Joint pain/arthritis | Gout | Stiffness
Back pain | Joint swelling

Seizure | Numbness/ tingling | Stroke/mini stroke | Weakness
Blackouts | Dizziness | Headaches | Tremor

Diabetes | Thyroid disorder | High Cholesterol | Hormone replacement
Excessive thirst/ appetite

Anxiety | Trouble sleeping | Depression
Suicidal ideation | Phobias | Hallucinations

Anemia | Bleeding disorder | Easy bruising/ bleeding
History of blood transfusion | Swollen glands

For Physician use only:

Reviewed by:

Date:

____
Sign your name