AdventHealth Ottawa

PATIENT HISTORY FORM

424 Main Street, Wellsville, KS 66092
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Please take the time to fully and completely fill out this history form. Thank You.

Patient Name _____ DOB _____ Age_____
The reason for your visit today _____

PERSONAL SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Spouse's Name _____
Number of Children _____ Patient's Occupation _____
Do you exercise? If so, what type_____ how often _____
Do you use tobacco? ❑ Y ❑ N if so, what type _____ how much _____ how long _____
Do you drink alcohol? ❑ Y ❑ N if so, how much _____how often_____
Do you use street drugs? ❑ Y ❑ N if so, what type _____ how often _____
Sexual Orientation: ❑ Heterosexual ❑ Homosexual ❑ Bisexual Do you practice safe sex? ❑ Y ❑ N
How many sexual partners in the last year? _____ What type of birth control do you use? _____
Date of last colonoscopy? _____ Date of last tetanus? _____ Date of last flu? _____

FEMALES ONLY

Date of last menstrual period _____ Date of last PAP _____ Number of pregnancies _____
History of abnormal PAPs ❑ Y ❑ N Date of last mammogram _____Date of last bone density _____

PERSONAL MEDICAL HISTORY (CHECK ALL THAT APPLY)

Cancer		**Endocrine/Metabolic**		**GU**		**HEET**	
Colon Cancer		Diabetes, non-insulin		Kidney Disease		Cataracts	
Breast Cancer		Diabetes, insulin dep		Kidney Stone		Glaucoma	
Skin Cancer		Gout		Kidney Infection		Blindness	
Cervical Cancer		Thyroid Disease		Urinary Tract Infection		Vision Loss	
Rectal Cancer		Other:		Incontinence		Hearing Loss	
Prostate Cancer		**GI**		Interstitial Cystitis		Respiratory	
Bladder Cancer		GERD		Erectile Dysfunction		**COPD**	
Kidney Cancer		Irritable Bowel		Other:		Asthma	
Testicle Cancer		Crohn's Disease		**Neuro/Psych**		Pneumonia	
Lung Cancer		Hemorrhoids		Anxiety		Bronchitis	
Other:		Diarrhea		Depression		Positive TB	
Cardiovascular		Pancreatitis		Seizure		**Musculoskeletal**	
Heart Bypass		Constipation		Stroke		Arthritis	
Heart Disease/Failure		Liver Disease		Parkinson's Disease		Back Pain	
High Blood Pressure		GI Bleed		Tension Headache		Fibromyalgia	
AICD/Pacemaker		Stomach Ulcer		Migraines		**General**	
Atrial Fibrillation		Other:		Alcohol/Drug Abuse		Allergies	
Heart Attack		**GYN/OB**		ADD/ADHD		Obesity	
Other:		Endometriosis		Other:		Sleep Apnea	
		Menopause				Hyperlipidemia	
		Other:					

Any other prior and current medical problems _____
Surgeries _____
Drug Allergies _____
What pharmacy do you use? _____

FAMILY MEDICAL HISTORY: M-Maternal, P-Paternal (please use chart above as a guide for family history)

Mother _____
Father _____
Siblings_____
Grandmother (M/P) _____ Grandfather (M/P) _____
Aunt (M/P) _____Uncle (M/P) _____

I verify that this information is true and correct to the best of my belief.

Patient Signature _____ **Date** _____