PATIENT HISTORY FORM

Please take the time to fully and completely fill out this history form. Thank You.

Patient Name: _____ Today's Date: _____ Age: _____

Primary Care Physician: _____ Referring MD: _____

The reason for your visit today: _____

Personal Social History

Marital Status: S M D W Spouses Name: _____

Patient's Occupation: _____ Number of Children: _____

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? _____

Caffeinated Beverages? None Low Moderate Excessive Last Flu vaccine date_____

Do you use street drugs? Y N If so, what type? _____ How often? _____

PERSONAL MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

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

Any Other: _____

Surgery: (Please list all) _____

_____

Drug Allergies: _____

Family Medical History – List any significant conditions

Mother: _____

Father: _____

Siblings: _____

Grandmother: _____ Grandfather: _____

Aunt: _____ Uncle: _____

In the past 30 days have you had any of the following symptoms or conditions? (please circle)

Blood in Urine	Headache	Weight Gain	Loss of Appetite	Muscle Pain
Urinate Air	Cough	Nausea/Vomiting	Excessive Thirst	Slurred Speech
Burning or Pain	Change in Vision	Constipation	Short of Breath	Hard of Hearing
with Urination	Fever or Chills	Fatigue	Numbness	Swollen Glands
Testicular Pain	Diarrhea	Blood in Stool	Ankle Swelling	Anxiety/Depression
Testicular Swelling	Weight Loss	Weakness	Back/Joint Pain	Rash/Itching

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

Patient/Parent Signature: _____ Date: _____