AdventHealth
Ottawa

PATIENT HISTORY FORM

1301 S. Main Street, Ottawa, KS (East Entrance)
833-RMH-CARE or 785-229-4050

Name:____ **Date of Birth**:__________________

Age:____________ **Sex**: ❑ M ❑ F **Height**:______________

Weight:_________________

Pharmacy:___________________________ **Family Physician**:______________________________

Have you had any falls recently? ❑ Y ❑ N **Are you a current/previous smoker**? ❑ Y ❑ N

Rate your pain from 0 (no pain) to 10 (the worst pain you've ever had)_____________________________

Why are you seeing the doctor today?____

List your symptoms____

(**Women Only**) When was your last menstrual period? ____

What are your current medications? **Please list names of medication and dosages**

____

____

____

____

Are you **allergic** to any medication? ____

Please list any and ALL surgeries or procedures you have ever had (list the year if known)

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____

____

Have you ever had problems with anesthesia in the past? ❑ Yes ❑ No

If yes, what reaction did you have?____

Do you have any of the following?

❑ Glaucoma	❑ Diabetes	❑ Kidney Disease	❑ Hard of Hearing
❑ Arthritis	❑ Colon Problems	❑ Cancer-- *What kind?* ______________	
❑ Hemorrhoids	❑ Seizure Disorder	❑ Stroke or TIA	❑ Heart Disease
❑ High Blood Pressure	❑ Pacemaker	❑ Mitral Valve Prolapse	❑ Irregular Heart Beat
❑ Heart Murmur	❑ Lung Disease	❑ Asthma	❑ Sleep Apnea

List any other medical history not listed above____

DO YOU TAKE:

Aspirin ❑ Y ❑ N
Coumadin ❑ Y ❑ N
Glucophage/Metformin ❑ Y ❑ N
Plavix ❑ Y ❑ N

ARE YOU ALLERGIC TO:

LATEX? ❑ Y ❑ N
DYES? ❑ Y ❑ N
TAPE? ❑ Y ❑ N

Have you had a CHEST X RAY in the past year? ❑ Y ❑ N If yes, when and where? ______________________

Have you had an EKG in the past year? ❑ Y ❑ N If yes, when and where? ______________________________

Have you ever had a COLONOSCOPY? ❑ Y ❑ N If yes, when and where? _____________________________

SOCIAL HISTORY

Alcoholic beverages? ❑ Y ❑ N How much? ❑ Daily ❑ Occasionally ❑ Rarely

Please circle: ❑ Wine ❑ Beer ❑ Liquor Is there a history of alcohol abuse? ❑ Y ❑ N

Do you use Illicit Drugs? ❑ Y ❑ N

What is your Marital Status? ❑ Married ❑ Single ❑ Divorced ❑ Widow(er)

Do you have a living will? ❑ Y ❑ N

Is your Mother living? ❑ Y ❑ N What is/was her health history?____

Is your Father living? ❑ Y ❑ N What is/was his health history?____

Please list any **Family History** of chronic illness or disease

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Is there a **Family History** of colon cancer? ❑ Y ❑ N If so, who?_______________________________________

Please return to the receptionist when you are done. Thank you.

Signature____ **Date:**________________________