Patient History Form

Date:_____

Name**:** Age:

Review of Systems:
(Please circle any of the following you currently experience)

General
Fatigue
Fever
Night Sweats

Skin
Dryness
Pruritis
Rash

HEENT
Head Injury
Tinnitus
Sinus Problems

Neck
Neck Pain
Neck Stiffness

Respiratory
Cough
Shortness of breath Wheezing

Cardiovascular
Chest pain
Feet Swelling
Palpitations

Gastrointestinal
Constipation
Diarrhea
Rectal Bleeding

Genitourinary
Frequency
Blood in urine
Hesitancy

Musculoskeletal
Muscle Weakness
Low Back Pain

Neurological
Headache
Seizure

Psychologic
Anxiety
Depression

Hematologic
Anemia

Allergies:

☐ No known allergies

☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Aspirin ☐ Latex

☐ Other: _____

_____

Immunizations:

Have you had an influenza vaccination in the past 12 months? ☐ Yes ☐ no

When was your last tetanus vaccination? _____

Family History:

☐ Cancer Who? _____

☐ High Blood Pressure Who? _____

☐ Heart Disease Who? _____

☐ Diabetes Who? _____

☐ Stroke Who? _____

☐ Spine Problems Who? _____

Patient Name: **Date of Birth:** **Date:**

Past Medical History:

Please indicate if you have:

☐ Cataracts	☐ Glaucoma	☐ Skin Cancer
☐ Chronic Bronchitis	☐ Tuberculosis	☐ Arrhythmia
☐ High Cholesterol	☐ Congestive Heart Failure	☐ Ulcerative Colitis
☐ Heart Burn (Reflux)(GERD)	☐ Diverticulitis	☐ Crohn's Disease
☐ Irritable Bowel Syndrome	☐ Hepatitis	☐ Urinary Tract Infections
☐ Prostate Cancer	☐ Diabetes	☐ Enlarged Prostate (BPH)
☐ Osteoarthritis	☐ Thyroid Disease	☐ Sleep Apnea
☐ Gout	☐ Rheumatoid Arthritis	☐ Heart Disease
☐ Lupus	☐ Pancreatitis	☐ COPD / Emphysema
☐ High Blood Pressure	☐ Blood Clots	☐ Asthma
☐ Psychiatric Depression	☐ Dental/Gum Treatment	☐ Any History of MRSA Infection

☐ Other: _____

Previous Surgeries:

☐ Appendix ☐ Tonsils ☐ Cataract ☐ Hysterectomy

☐ Cervical Spine ☐ Lumbar Spine ☐ Gallbladder ☐ Tubal Ligation

☐ Carpal Tunnel Surgery

☐ Other: _____

_____

Social History:

☐ Single ☐ Married ☐ Divorced ☐ Widow / Widower

Ethnicity

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Indian (India & Pakistan) ☐ Middle Eastern

Number of Children: _____ Are they healthy? _____

Alcohol Use: ☐ Yes ☐ No Amount? _____

Tobacco Use: ☐ Yes ☐ No Amount? _____

How many years? _____

Previously used tobacco? ☐ Yes ☐ No Amount? _____

How many years? _____

Occupation: _____

Are you currently working? ☐ Yes ☐ No ☐ Retired

Last work date _____