PATIENT HISTORY FORM

Last Name: _____ First Name: _____ Middle: _____

Social Security No. _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

What is the reason for your visit today?_____
_____
_____

PAST MEDICAL HISTORY

List your present medications (include over-the-counter):

Medication	Dosage/Frequency	Medication	Dosage/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you on a blood thinner? Yes ____ No _____

List all past/present medical illnesses:

_____ _____
_____ _____
_____ _____

List previous surgeries/hospitalizations:

Surgery/Hospitalization	Approximate Date
_____	_____
_____	_____
_____	_____

List all allergies (medication, food, etc.):

_____ _____
_____ _____
_____ _____

Date of: Last chest x-ray? ___/___/___ Prior EKG? ___/___/___ Prior allergy test ___/___/___

SOCIAL HISTORY

Marital Status? Married _____ Single _____ Divorced _____ Widowed _____

Do you: Smoke yes _____ No _____ If yes, how many packs per day _____
Drink yes _____ No _____ If yes, circle one: wine beer whiskey
Chew yes _____ No _____

Are you a previous smoker? yes _____ No _____ If yes, when did you quit? _____
Do you have a history of alcohol or substance abuse? Yes _____ No _____

FAMILY HISTORY

List all serious illnesses in your immediate family (diabetes, cancer, heart disease, high blood pressure, asthma, etc.)

Illness	Family Member
_____	_____
_____	_____

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following? Circle **Y**es or **N**o.

Ear:
Decreased Hearing Y N
Pain Y N
Fullness Y N

Nose:
Blockage/Breathing Y N
Congestion Y N
Drainage Y N
Infection Y N
Trauma Y N
Sneezing Y N
Bleeding Y N
Loss of Smell Y N

Throat:
Lumps/Growth Y N
Pain Y N
Swelling Y N
Abscess Y N
Tonsillitis Y N
Hoarseness Y N
Voice Change Y N
Loss of Voice Y N

Sinus:
Eye/Facial Swelling Y N
Change in Vision Y N
Pain Y N
Pressure Y N
Drainage Y N
Headaches Y N
Infection Y N
Congestion Y N
Polyps Y N

Mouth:
Sores on Tongue Y N
Gums Swelling Y N
Lumps/Growth Y N

Eyes:
Watery Y N
Itching Y N
Change in vision Y N
Redness Y N
Other _____

Neurological:
Tremors Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Headache Y N
Other _____

Endocrine:
Excessive Thirst Y N
Too Hot/Cold Y N
Tired/Sluggish Y N
Other _____

Gastrointestinal:
Abdominal Pain Y N
Nausea/Vomiting Y N
Indigestion/Heartburn Y N
Night Time Cough Y N
Other _____

Cardiovascular:
Chest Pain Y N
High Blood Pressure Y N
Varicose Veins Y N

Skin:
Skin Rash Y N
Boils Y N
Persistent Itch Y N
Other _____

Musculoskeletal:
Joint pain Y N
Neck pain Y N
Back Pain Y N
Other _____

Respiratory:
Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other _____

Hematological/Lymphatic:
Swollen Glands Y N
Blood Clotting Problem Y N
Other _____

Psychological/Emotional:
Depression Y N
Anxiety Y N
Medication Y N
Other _____

Allergic/Immunological:
Hay Fever Y N
Drug Allergies Y N
Food Allergies Y N
Hives Y N
Behavioral Problems Y N
Other _____

_____ _____
Practitioner Signature Date