Print Form

Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.

Name _____ Date _____ Date of Birth ___/___/___ Age ___

Chief Complaint/History of Present Illness

What is the reason for your visit? (Be as specific as possible)

Past Medical History

Have you ever had any of the following?

☐ Anemia	☐ Cancer	☐ Seizures	☐ Asthma
☐ Heart Disease	☐ Gall Bladder Disease	☐ Migraines	☐ Pneumonia
☐ High Blood Pressure	☐ Blood transfusion	☐ Liver disease	☐ Diabetes
☐ Rheumatic Fever	☐ Pelvic Infection	☐ Depression/Anxiety	☐ Sickle Cell Trait
☐ Mitral Valve Prolapse	☐ Bladder Infections	☐ Drug or Alcohol Problem	☐ Blood clot in legs/lung
☐ Thyroid problem	☐ Genital Herpes	☐ Gonorrhea/Syphilis/Chlamydia	☐ Osteopenia

Last colonoscopy _____ Last bone density _____ Last cholesterol check _____

Are you on any medications? Y☐ N☐ (If yes, list all) _____

Do you have any allergies? Y☐ N☐ (If yes, list all) _____

Please list all hospitalizations and surgeries with dates:

Past Obstetrical History

Please list all pregnancies in order (including miscarriages, premature births, abortions, etc...):

Year	Sex	Weight	Type of Delivery	Weeks Pregnant	Anesthetic	Complications

Past Gynecologic History

Date of beginning of last menstrual period _____ Method of birth control _____

Age of first period _____ Are your periods regular? Y☐ N☐

Cycle length _____ Flow: Light☐ Moderate☐ Heavy☐ Pain or cramping? Y☐ N☐

Date of last pap smear _____ Are you sexually active? Y☐ N☐ Past abnormal pap smear? Y☐ N☐

Have you had treatment for an abnormal pap smear? (please list what and when) _____

Date of last mammogram _____ Was it normal? Y☐ N☐

Social History

Do you smoke? Y ☐ N ☐ How much? _____ For how long? _____
Do you drink alcohol? Y ☐ N ☐ How much? _____ For how long? _____
Do you use any street drugs? Y ☐ N ☐ If yes, please list _____

Family History

Has any relative ever had:

	Who		Who		Who
☐ Inherited disease		☐ Heart Trouble		☐ Mental Illness	
☐ Cancer		☐ High Blood Pressure		☐ Stroke	
☐ Diabetes		☐ Kidney Trouble		☐ Tuberculosis	
☐ Epilepsy		☐ Sickle Cell Disease		☐ Bleeding Problems	

Review of Symptoms

Do you currently have any of the following problems? Please check Yes or No

Constitutional Symptoms
Fever/Chills Y ☐ N ☐
Weight loss Y ☐ N ☐
Headache Y ☐ N ☐

Eyes
Blurred Vision Y ☐ N ☐
Double Vision Y ☐ N ☐
Vision Changes Y ☐ N ☐

Allergic/Immunologic
Hay fever Y ☐ N ☐
Medications Y ☐ N ☐

Neurologic
Dizziness Y ☐ N ☐
Seizures Y ☐ N ☐
Numbness/tingling Y ☐ N ☐

Endocrine
Hair loss Y ☐ N ☐
Heat/cold intolerance Y ☐ N ☐

Gastrointestinal
Nausea/vomiting Y ☐ N ☐
Constipation/diarrhea Y ☐ N ☐
Abdominal pain Y ☐ N ☐

Cardiovascular
Chest pain Y ☐ N ☐
Difficulty breathing Y ☐ N ☐
Swelling Y ☐ N ☐
Palpitations Y ☐ N ☐

Respiratory
Wheezing Y ☐ N ☐
Shortness of breath Y ☐ N ☐
Cough Y ☐ N ☐
Sleep apnea Y ☐ N ☐

Musculoskeletal
Joint pain Y ☐ N ☐
Muscle weakness Y ☐ N ☐
Muscle pain Y ☐ N ☐

Ear/Nose/Throat/Mouth
Sore throat Y ☐ N ☐
Sinus problems Y ☐ N ☐
Hearing problems Y ☐ N ☐
Hot flashes Y ☐ N ☐
Excessive thirst Y ☐ N ☐

Hematologic/Lympahatic
Swollen glands Y ☐ N ☐
Frequent bruising Y ☐ N ☐

Psychiatric
Depression/Crying Y ☐ N ☐
Anxiety Y ☐ N ☐
Thoughts of suicide Y ☐ N ☐

Skin
Rash/sores Y ☐ N ☐
Mole changes Y ☐ N ☐

Breast
Nipple discharge Y ☐ N ☐
Lumps Y ☐ N ☐
Skin changes Y ☐ N ☐

Genitourinary
Urine leakage Y ☐ N ☐
Urine retention Y ☐ N ☐
Burning w/urination Y ☐ N ☐
Frequent urination Y ☐ N ☐
Vaginal discharge Y ☐ N ☐
Abnormal bleeding Y ☐ N ☐
Painful periods Y ☐ N ☐
Painful intercourse Y ☐ N ☐
Fibroids Y ☐ N ☐
Infertility Y ☐ N ☐