PATIENT HISTORY

Date: _____

Name	☐ Female ☐ Male	Birthdate:	Age

HEALTH HISTORY: *(Please check if you have or have ever had any of the following)*

Mumps	Yes ☐	No ☐	Gout	Yes ☐	No ☐	Varicose Veins	Yes ☐	No ☐
Measles	Yes ☐	No ☐	Low Blood Sugar	Yes ☐	No ☐	Stomach Pain	Yes ☐	No ☐
German Measles	Yes ☐	No ☐	Ulcers	Yes ☐	No ☐	Hernia	Yes ☐	No ☐
Scarlet Fever	Yes ☐	No ☐	Problem with Vision	Yes ☐	No ☐	Recurrent Nosebleeds	Yes ☐	No ☐
Chicken Pox	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐	Headaches / Migraine	Yes ☐	No ☐
Polio	Yes ☐	No ☐	Gallbladder Disease	Yes ☐	No ☐	Overnight Urination	Yes ☐	No ☐
Meningitis	Yes ☐	No ☐	Persistent Hoarseness	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Syphilis	Yes ☐	No ☐	Difficulty Swallowing	Yes ☐	No ☐	Cough Up Blood	Yes ☐	No ☐
Jaundice	Yes ☐	No ☐	Chest Pain	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Cancer	Yes ☐	No ☐	Dentures	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐	Night Sweats	Yes ☐	No ☐	Frequent Constipation	Yes ☐	No ☐
Sugar Diabetes	Yes ☐	No ☐	Rashes	Yes ☐	No ☐	Frequent Diarrhea	Yes ☐	No ☐
Chronic or Frequent Cough	Yes ☐	No ☐	Shortness of Breath	Yes ☐	No ☐	Blood in Stools	Yes ☐	No ☐
Glasses	Yes ☐	No ☐	Palpitations	Yes ☐	No ☐	Dark Stool	Yes ☐	No ☐
Contact Lens	Yes ☐	No ☐	Back Problems	Yes ☐	No ☐	Kidney Stones	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Swelling of Feet	Yes ☐	No ☐	Urine Lost with Coughing Or Sneezing	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐	Thyroid Disease	Yes ☐	No ☐			

Other Problems: _____

Appetite: ☐ Good ☐ Fair ☐ Poor **Vomiting:** ☐ Seldom ☐ Frequent **Nausea:** ☐ Seldom ☐ Frequent

Menstrual: ☐ Regular ☐ Irregular ☐ Cramping ☐ Heavy ☐ Normal **Hysterectomy:** ☐ Yes ☐ No No. Pregnancies: _____

Weight Today: _____ **Weight 1 Year Ago:** _____ **Height:** _____ ft _____ in

ALLERGIES: *(Please list allergies, sensitivities, and/or reactions to any drugs or vaccines)* _____

_____

MEDICATIONS: *(Please list all medications you are currently taking)* _____

_____

PERSONAL HABITS: **Smoking:** Packs/day _____ How many years? _____ **Alcohol:** Amount/day _____ How many years? _____

MEDICAL/SURGICAL: *(Please list any hospitalizations, injuries, surgies, serious and/or unusual illnesses which you have experienced)*

Year _____ _____ Year _____ _____

Year _____ _____ Year _____ _____

Year _____ _____ Year _____ _____

FAMILY HISTORY: *(Please check if any blood relative has or has ever had any of the following)*

Thyroid	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Heart Attack	Yes ☐	No ☐	Migraine	Yes ☐	No ☐
Mental Illness	Yes ☐	No ☐	Gout	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Kidney Disease	Yes ☐	No ☐	Cancer	Yes ☐	No ☐	Breast Cancer	Yes ☐	No ☐	Cholesterol	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐	Allergy	Yes ☐	No ☐	Triglyceride	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐									

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____ _____ _____

Patient Signature Date Provider Signature Date