

## PATIENT HISTORY

PATIENT: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

COMPLAINT (State reason you want to see doctor): \_\_\_\_\_

Referring MD or Primary MD: \_\_\_\_\_ Patient's Phone#(\_\_\_\_) \_\_\_\_\_

### MEDICAL HISTORY

**Major Illnesses:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Operations/Surgery:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Injuries:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Other:** \_\_\_\_\_  
 \_\_\_\_\_

**Medications:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Drug/Food Allergies:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pregnancy History: No. of Pregnancies: \_\_\_\_\_

No. of Living Children: \_\_\_\_\_

 Complications:  No  Yes If "yes", Explain: \_\_\_\_\_  
 \_\_\_\_\_

**Immunizations: (Up - To - Date)**  Yes  No \_\_\_\_\_

### REVIEW OF SYSTEMS

*Check any items you may have problems with:*

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Liver       | <input type="checkbox"/> Blood Pressure   |
| <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Joint Pain  | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Stomach            | <input type="checkbox"/> Bowel       | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Kidney/Bladder     | <input type="checkbox"/> Skin Rashes | <input type="checkbox"/> Cancer           |
| <input type="checkbox"/> Asthma/Lung        | <input type="checkbox"/> Heart       |   |

### FAMILY HISTORY

*Check any illness your immediate family may suffer from:  
 (father, mother, brother, sister)*

- |  |   |
|--|---|
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Heart Disease before age 60 | <input type="checkbox"/> Cancer           |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Other: _____                |   |

### SOCIAL HISTORY *Check items as appropriate:*

**MARITAL STATUS**

- 
- Single
- 
- 
- Married
- 
- 
- Divorced
- 
- 
- Separated
- 
- 
- Widowed

**LIVING ARRANGEMENTS**

- 
- Live Alone
- 
- 
- Spouse/Children
- 
- 
- Relative
- 
- 
- Other: \_\_\_\_\_

**PRIMARY CAREGIVER**

- 
- Self
- 
- 
- Spouse
- 
- 
- Relative
- 
- 
- Other: \_\_\_\_\_

**ITEMS YOU HAVE BEEN EXPOSED TO**

- 
- Asbestos
- 
- 
- Loud Noises
- 
- 
- Industrial Toxins
- 
- 
- Smoke/Fumes
- 
- 
- Pesticides
- 
- 
- Stress/Pressure
- 
- 
- Heavy Lifting, Physical Strain
- 
- 
- Extreme Heat or Cold
- 
- 
- Other: \_\_\_\_\_

**MAJOR LIFE STRESSES**

- 
- School
- 
- 
- Work
- 
- 
- Divorce
- 
- 
- Other: \_\_\_\_\_

**ITEMS YOU NEED ASSISTANCE WITH**

- 
- Bathing
- 
- 
- Eating
- 
- 
- Transportation
- 
- 
- Meal Preparation
- 
- 
- Dressing
- 
- 
- Other: \_\_\_\_\_

**Who provides assistance:** \_\_\_\_\_

### MISCELLANEOUS INFORMATION

**Occupation:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employer's Phone:** (\_\_\_\_) \_\_\_\_\_

**Education: (highest grade completed.)** \_\_\_\_\_  
 \_\_\_\_\_

**Religious Preference:** \_\_\_\_\_

### HABITS

**Hobbies:** \_\_\_\_\_

**Pets:** \_\_\_\_\_

**Caffeine:** \_\_\_\_\_

**Drugs:** \_\_\_\_\_

**Describe Regular Exercise:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Alcohol:**

Ounces per day: \_\_\_\_\_

How many years: \_\_\_\_\_

**Smoking:**

Packs per day: \_\_\_\_\_

How many years: \_\_\_\_\_

When quit: \_\_\_\_\_