PATIENT HISTORY FORM

Patient's Name: ______________________ Today's Date: __________

Social Security Number: ______________________ Date of Birth: __________

Past Medical History

Previous Physician's Name: ______________________ Date of Last Exam: __________

Have you ever been hospitalized? ☐ Yes ☐ No If yes, what for? ______________________

____

Have you ever been tested for hepatitis A, B or C? ☐ Yes ☐ No Which hepatitis virus? __________

Have you been vaccinated for hepatitis B? ☐ Yes ☐ No If yes, date vaccine series completed: __________

Have you been vaccinated for hepatitis A? ☐ Yes ☐ No If yes, date vaccine series completed: __________

Last Tuberculosis (TB) Screening? __________ Result of TB Screening: ☐ Positive ☐ Negative

If positive TB screen, date of last chest x-ray: __________ Result of chest x-ray: ☐ Positive ☐ Negative

Have you had a sexually transmitted disease? ☐ Yes ☐ Diagnosis: ______________________

Which of the follow conditions are you currently being treated or have been treated for in the past *(please check)*

☐ Heart Disease / Murmur / Angina	☐ Shortness of Breath	☐ Eye Disorder / Glaucoma	☐ Diabetes
☐ High Cholesterol	☐ Asthma	☐ Seizures	☐ Kidney / Bladder Problems
☐ High Blood Pressure	☐ Lung Problems / Cough	☐ Stroke	☐ Liver Problems / Hepatitis
☐ Low Blood Pressure	☐ Sinus Problems	☐ Headaches / Migraines	☐ Arthritis
☐ Heartburn (reflux)	☐ Seasonal Allergies	☐ Neurological Problems	☐ Cancer
☐ Anemia or Blood Problems	☐ Tonsillitis	☐ Depression / Anxiety	☐ Ulcers / Colitis
☐ Swollen Ankles	☐ Ear Problems	☐ Psychiatric Care	☐ Thyroid Problems

Please describe any current or past medical treatment not listed above

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____

Please list your past surgeries

____

____

____

____

Allergies

Are you allergic to penicillin or any other drugs? ☐ Yes ☐ No

Please list: ______________________

____

Medications

Please list: ______________________

____

____

Social and Preventive History

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many packs per day?____________

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many drinks per week? ___________

Do you currently drink coffee and/or tea? ☐ Yes ☐ No If yes, how many cups per day?___________

Do you exercise daily/weekly? ☐ Yes ☐ No

Do you use seat belts while driving? ☐ Yes ☐ No Do you wear a helmet while riding a bike? ☐ Yes ☐ No

Family History

	Living		Age (or age at death)	List Serious Illnesses
Mother	☐ Yes	☐ No	______	______________________________
Father	☐ Yes	☐ No	______	______________________________
Sisters	☐ Yes	☐ No	______	______________________________
	☐ Yes	☐ No	______	______________________________
	☐ Yes	☐ No	______	______________________________
Brothers	☐ Yes	☐ No	______	______________________________
	☐ Yes	☐ No	______	______________________________
	☐ Yes	☐ No	______	______________________________

Has any member of your family (including children and parents) had any of the following illnesses?

Illness	Which family member?
Anemia or Blood Disease	____________________
Cancer	____________________
Diabetes	____________________
Glaucoma	____________________
Heart Disease	____________________
High Blood Pressure	____________________
HIV Disease / AIDS	____________________
Mental Illness / Depression	____________________
Stroke	____________________
Other Serious Illness	____________________

Females: Gynecological History

How many times have you been pregnant?___________ Date of Last Pap Smear:____________________

Have you had an abnormal Pap Smear? ☐ Yes ☐ No Diagnosis:____________________ Follow-up: __________

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis: ____________________

Date of last mammogram: ____________________ Mammogram Results: ____________________

Have you ever had a breast biopsy? ☐ Yes ☐ No Biopsy Results:____________________

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient / Legal Guardian Signature:______________________________ **Date:**____________________

Provider / Reviewer:______________________________ **Date:**____________________