PATIENT HISTORY FORM

Last Name _____ First Name _____ MI ____

Date of Birth _____ Marital Status (please √) ☐ single ☐ married ☐ divorced ☐ widow

Allergies to medications:_____

Do you smoke? ☐ no ☐ yes how much? _____ **Do you drink alcohol?** ☐ no ☐ yes how much? _____

If you used to smoke when did you quit? _____

PAST MEDICAL HISTORY

CONDITIONS (please √ ALL THAT APPLY)

- ☐ ABNORMAL PAP SMEAR
- ☐ ANOREXIA-EATING DISORDER
- ☐ ARTHRITIS/GOUT
- ☐ ASTHMA/EMPHYSEMA
- ☐ BLOOD DISORDERS/ANEMIA
- ☐ BREAST LUMP/BIOPSIES
- ☐ CANCER
- ☐ CATARACTS/GLAUCOMA
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ WEIGHT ISSUES
- ☐ VAGINAL INFECTIONS
- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ HEADACHE/MIGRAINES
- ☐ HERNIA
- ☐ HEPATITIS
- ☐ HIGH CHOLESTEROL
- ☐ HIV POSITIVE
- ☐ KIDNEY DISEASE
- ☐ LEG CRAMPS
- ☐ LIVER DISEASE
- ☐ IRREGULAR PERIODS
- ☐ HEAVY PERIODS
- ☐ MULTIPLE SCLEROSIS
- ☐ POLIO
- ☐ PROSTATE ENLARGEMENT
- ☐ UNDER PSYCHIATRIC CARE
- ☐ HX OF SEXUALLY TRANSMITTED DISEASE
- ☐ STROKE/TIA
- ☐ SUBSTANCE ABUSE
- ☐ THYROID PROBLEMS
- ☐ TB
- ☐ ULCERS
- ☐ URINARY PROBLEMS (URGENCY/PAIN/LEAKAGE)
- ☐ _____

CURRENT MEDICATION NAMES AND DOSEAGE:

_____

_____

Do you take any weight loss products, herbs, & vitamins? ☐ no ☐ yes If yes please list:

_____

SURGERIES/HOSPITALIZATIONS (list year and reason for Hospitalization)

_____

_____

Do you exercise on a regular basis? ☐ no ☐ yes If yes, what activity? _____ how often? _____

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	AGE OF DEATH	CAUSE
FATHER				
MOTHER				
SISTER(S)				
BROTHER(S)				
GRANDPARENTS				

PLEASE CHECK IF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING DISEASES:

	(RELATIONSHIP)		(RELATIONSHIP)
☐ ARTHRITIS	_____	☐ HEART DISEASE	_____
☐ ASTHMA/EMPHYSEMA	_____	☐ HIGH BLOOD PRESSURE	_____
☐ CANCER	_____	☐ STROKE	_____
☐ DIABETES	_____	☐ KIDNEY DISEASE	_____

PATIENT SIGNATURE _____ DATE _____