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**** BRING THIS FORM WITH YOU THE DAY OF APPOINTMENT *****

PATIENT HISTORY FORM

Date: _____

Patient Name: _____ Age: _____ DOB: _____ Marital Status: _____ Occupation: _____

Primary Care Physician: _____

Pharmacy Name, Location & Phone #: _____

SURGERIES / HOSPITALIZATIONS: (Please list all hospitalizations for surgeries or illness)

	DATE	TYPE OF OPERATION	WHERE PERFORMED
1.			
2.			
3.			
4.			
5.			
6.			

MEDICAL CONDITIONS:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ALLERGIES / Reaction: **No Known Allergies:** ☐

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICATIONS: (Please list all medications you are currently taking, including prescription & non-prescription, dosage and frequency.)

MEDICATION	DOSE	FREQUENCY (How Often)	MEDICATION	DOSE	FREQUENCY (How Often)

SOCIAL HISTORY:

USE OF ALCOHOL: ____ Never ____ Rarely ____ Moderate ____ Daily

USE OF TOBACCO: ____ Never ____ Previously, but quit. When? _____ ____ Current User
(How much: _____) (Packs per day: _____)

USE OF DRUGS: ____ Never ____ Previously, but quit. ____ Current User
(Type: _____) (Type / frequency): _____)

FIRST DEGREE RELATIVE SUBSTANCE ABUSE PROBLEMS: _____ NO ____ YES, WHOM: _____

FAMILY MEDICAL HISTORY:

DO YOU HAVE ANY FAMILY HISTORY OF COLON POLYPS? ____ NO ____ YES, WHOM: _____

DO YOU HAVE ANY FAMILY HISTORY OF COLON CANCER: ____ NO ____ YES, WHOM: _____

	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH
FATHER			
MOTHER			
SIBLINGS			
CHILDREN			

(Please indicate any personal history below)

CONSTITUTIONAL SYMPTOMS

Fever ____ YES ____ NO
Fatigue ____ YES ____ NO

EYES

Double vision ____ YES ____ NO

EARS, NOSE, MOUTH, THROAT

Hearing loss ____ YES ____ NO
Ringing in ears ____ YES ____ NO
Earaches ____ YES ____ NO
Nosebleeds ____ YES ____ NO
Bad Taste ____ YES ____ NO
Bad Breath ____ YES ____ NO
Swollen glands in neck ____ YES ____ NO

CARDIOVASCULAR

Chest pain ____ YES ____ NO
Angina ____ YES ____ NO
Palpitation ____ YES ____ NO
Swelling of feet, ankles, hands ____ YES ____ NO
Heart attack ____ YES ____ NO
Heart valve replacement ____ YES ____ NO
Hypertension ____ YES ____ NO
Pacemaker (Internal Defibrillator) ____ YES ____ NO
Mitral Valve Prolapse ____ YES ____ NO

RESPIRATORY

Chronic cough ____ YES ____ NO
Spitting up blood ____ YES ____ NO
Shortness of Breath ____ YES ____ NO
Asthma ____ YES ____ NO
Wheezing ____ YES ____ NO
Emphysema ____ YES ____ NO
Tuberculosis ____ YES ____ NO
Sleep apnea ____ YES ____ NO

GASTROINTESTINAL

Difficulty swallowing ____ YES ____ NO
Loss of appetite ____ YES ____ NO
Recent weight Loss ____ YES ____ NO
Change in bowel movements ____ YES ____ NO
Constipation ____ YES ____ NO
Rectal Bleeding ____ YES ____ NO
Blood in stool ____ YES ____ NO
Abdominal pain ____ YES ____ NO
Polyps ____ YES ____ NO
Heartburn/Reflux/Indigestion ____ YES ____ NO
Nausea ____ YES ____ NO
Vomiting ____ YES ____ NO
Frequent diarrhea ____ YES ____ NO
Painful bowel movements ____ YES ____ NO

GENITOURINARY

Frequent Urination ____ YES ____ NO
Burning or painful urination ____ YES ____ NO
Blood in urine ____ YES ____ NO
Kidney Stones ____ YES ____ NO

MUSCULOSKELETAL

Joint pain ____ YES ____ NO
Weakness ____ YES ____ NO
Back pain ____ YES ____ NO
Fibromyalgia ____ YES ____ NO

INTEGUMENTARY (skin)

Rash ____ YES ____ NO
Change in skin color ____ YES ____ NO
Change in hair ____ YES ____ NO
Change in nails ____ YES ____ NO
Itching ____ YES ____ NO

NEUROLOGICAL

Seizures ____ YES ____ NO
Confusion ____ YES ____ NO
Frequent Headaches ____ YES ____ NO
Numbness ____ YES ____ NO
Tingling ____ YES ____ NO
Tremors ____ YES ____ NO
Stroke ____ YES ____ NO
Memory loss ____ YES ____ NO

ENDOCRINE

Excessive thirst ____ YES ____ NO
Heat intolerance ____ YES ____ NO
Cold intolerance ____ YES ____ NO
Diabetes ____ YES ____ NO
Hypothyroidism ____ YES ____ NO
Hyperthyroidism ____ YES ____ NO

HEMATOLOGIC / LYMPHATIC

Bleeding tendency ____ YES ____ NO
Bruising tendency ____ YES ____ NO
Anemia ____ YES ____ NO
Phlebitis ____ YES ____ NO
Transfusions ____ YES ____ NO
Blood Thinners (Coumadin, Plavix, Warfarin, etc.) ____ YES ____ NO

REPRODUCTION

Pregnant ____ YES ____ NO ____ N/A
Breast-feeding ____ YES ____ NO ____ N/A

OTHER

Cancer ____ YES ____ NO
If YES, what type: _____
Night Sweats ____ YES ____ NO

To 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 changed in my medical status. I also authorize the health care staff to perform the necessary services that I may need.

Patient / Guardian Signature: _____

(If Not patient, relationship: _____) Date: _____