Patient History Form

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Name: _____DOB: _____ Date: _____

What is the major reason for today's visit? _____

Personal History

Birthplace_____
Date of Birth_____
Nationality_____
Marital Status_____
Occupations_____
_____
Recreation_____
Exercise_____
Average per day
Alcohol _____
Tobacco _____
Tea, Coffee_____

Medical History

Have you had any of the following? Circle those which apply and give dates where appropriate.

Measles
Mumps
Whooping Cough
Polio
Scarlet fever
Diphtheria
Meningitis
Infectious Mono
Valley Fever
Tuberculosis
Exposure to TB
Skin test positive to TB
Malaria
Hives
Cancer
Type_____
Pneumonia
Bronchitis
Pleurisy
Asthma
Emphysema
Rheumatic Fever
Arthritis
Back Trouble
Venereal disease

Medical History

Have you had any of the following? Circle those which apply and give dates where appropriate.

High blood pressure
Heart disease
Heart attack
Diabetes Juvenile
Diabetes adult onset
Stroke
Seizure
Anemia
Bleeding Tendency
Blood transfusion
Hepatitis (yellow jaundice)
Ulcer
Hemorrhoids
Bladder infections
Kidney disease
Hay fever/sinusitis
Glaucoma
Nose bleeds

Surgical History

Have you had any of the following operations? Circle those which apply and give dates where appropriate.

Coronary bypass surgery
Heart valve replacement
Tonsils
Appendix
Gall bladder
Stomach
Breast
Uterus and /or ovary
Prostate
Hernia
Thyroid
Varicose
Veins
Hemorrhoids
Heart
Other _____

Injury History
Have you had any of the following injuries? Circle those which apply and give dates where appropriate.

Head
Chest
Abdomen
Broken Bones
Back
Other _____

Allergies
Have you had allergies to any of the following medications? Circle those which apply

Tetanus antitoxin
Penicillin
Sulfa
Other drugs _____
_____
Foods
Cosmetics
Other _____

Immunizations
Have you had the following immunizations? Circle those which apply and give dates where appropriate.

Smallpox
Tetanus
Polio
Flu shot
Pneumovax
Other_____

Family History
Do you have a family history of any of the following medical conditions? Circle those which apply and list relationship.

Anemia
Bleeding Tendency
Leukemia
Repeated infections
Crippling infections
Heart disease
Chronic lung disease
Tuberculosis
High blood pressure
Kidney disease
Asthma
Severe allergies

Family History continued *Circle those which apply and list relationship.*

Mental illness
Convulsions
Migraine headaches
Diabetes
Gout
Obesity
Thyroid trouble
Peptic ulcer
Chronic diarrhea
Cancer

Systems Review
Have you recently had the following?

General	**Yes**	**No**
Tire easily	☐	☐
Weakness	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
Sensitivity to heat	☐	☐
Sensitivity to cold	☐	☐
Skin		
Rash	☐	☐
Change in color	☐	☐
Change in hair	☐	☐
Change in nails	☐	☐
Eyes		
Trouble seeing	☐	☐
Eye pain	☐	☐
Inflamed eyes	☐	☐
Double vision	☐	☐
Worn glasses	☐	☐
Ears		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
Discharge from ears	☐	☐
Nose		
Loss of smell	☐	☐
Frequent colds	☐	☐
Obstruction	☐	☐
Excess discharge	☐	☐
Nosebleeds	☐	☐
Mouth		
Sore gums	☐	☐
Soreness of tongue	☐	☐
Dental problems	☐	☐

Systems Review continued

Have you recently had the following?

Throat	**Yes**	**No**
Postnasal drainage	☐	☐
Soreness	☐	☐
Hoarseness	☐	☐
Change in voice	☐	☐
Breasts		
Lumps	☐	☐
Discharge	☐	☐
Heart		
Chest pain	☐	☐
Palpitations	☐	☐
Short of breath while lying	☐	☐
High blood pressure	☐	☐
Vein problems	☐	☐
Lungs		
Cough	☐	☐
Cough at night	☐	☐
Sputum (phlegm)	☐	☐
Bloody sputum	☐	☐
Wheezing	☐	☐
Pain on breathing in chest	☐	☐
Shortness of breath	☐	☐
Shortness of breath with exertion	☐	☐
Swelling in ankles	☐	☐
Bluish fingers or lips	☐	☐
Abdomen		
Change in appetite	☐	☐
Difficulty in swallowing	☐	☐
Heartburn	☐	☐
Belching	☐	☐
Excess gas	☐	☐
Abdominal enlargement	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Vomiting blood	☐	☐
Rectal bleeding	☐	☐
Bloody stools	☐	☐
Dark urine	☐	☐
Jaundice	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Hemorrhoids	☐	☐
Need for laxatives	☐	☐

Kidney and Urinary	**Yes**	**No**
Increase in urination at night	☐	☐
Unable to hold urine	☐	☐
Impotence	☐	☐
Lack of sex drive	☐	☐
Pain with intercourse	☐	☐
Endocrine		
Thyroid nodule or mass	☐	☐
High thyroid level	☐	☐
Low thyroid level	☐	☐
Adrenal trouble	☐	☐
High blood sugars	☐	☐
Low blood sugars	☐	☐
Muscular		
Muscle cramps	☐	☐
Muscle weakness	☐	☐
Pain in joints	☐	☐
Swollen joints	☐	☐
Joint stiffness	☐	☐
Deformity of joints	☐	☐
Nervous System		
Headaches	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Convulsions or seizures	☐	☐
Nervousness	☐	☐
Depression	☐	☐
Change in sensation	☐	☐
Memory loss	☐	☐
Poor coordination	☐	☐
Weakness	☐	☐
Paralysis	☐	☐
Sleep Disorders		
Snoring	☐	☐
Excessive daytime sleepiness	☐	☐
Pauses in breathing during sleep	☐	☐
Insomnia	☐	☐
Sleeplessness	☐	☐
Sleepiness while driving	☐	☐

Gyn-OB

Age started menstruation _____

Date of last pap test _____

Interval between periods _____

Duration of period _____

Date of last period _____

Number of pregnancies _____

Miscarriages _____

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