



PATIENT HISTORY

Date: _____

Name: _____ Date of birth: _____

Primary care physician: _____

Referring physician: _____

Pharmacy: _____

Reason for today's visit: _____

Date of onset/length of symptoms: _____

Past medical history: Please circle all that apply.

Allergies	Asthma	Bleeding disorder	Cancer, Type:
Diabetes	Reflux	Heart disease	Heart attack
Hepatitis	Hypertension	Kidney problems	Lung disease
Seizures	Sleep apnea	Stroke	Thyroid disease

Other: _____

Surgical history: _____

Date of last flu vaccine: _____ Date of last pneumonia vaccine: _____

Please list all current medications: No current medications

Name	Dose	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications? No Yes, if yes, please list: _____

Social history: Please check all that apply

Tobacco use: Smoke cigarettes: Never No Yes

Quit date: _____ How many years did you smoke? _____

Current smoker: Packs/day: _____ # of years: _____

Smokeless tobacco: No Yes E-cigarette use: No Yes

Exposure to secondary smoke: No Yes

Alcohol use: None Occasional Moderate Heavy

Daycare attendance: No Yes Grade in school: _____

Family history: Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mom/Dad	Brother/Sister	Other
Allergies			
Anesthesia problems			
Bleeding disorder			
Cancer: Type			
Diabetes			
Hearing loss			
Heart disease			

Review of systems: Please mark the box of any persistent symptoms you have had in the last few months.

General

- Unexplained weight loss/gain
- Unexplained fatigue
- Fever/chills

Respiratory

- Asthma
- Coughing/wheezing
- Shortness of breath

Musculoskeletal

- Arthritis
- Back pain
- Muscle weakness

Hematologic/Lymphatic

- Anemia
- Swollen nodes/glands
- Easy bruising/bleeding

Skin

- Dry skin
- Skin discoloration
- Rash/hives

Cardiac

- Chest pain
- Fast or irregular heartbeat
- Hypertension

Neurological

- Headaches
- Fainting
- Seizures

Eyes

- Itchy eyes
- Watery eyes
- Pain around eyes

GI

- Heartburn
- Reflux
- Swallowing difficulty

Endocrine

- Heat or cold sensitivity
- Hot flashes
- Thyroid problems

Patient signature _____ Date _____

Physician comments: