

# PATIENT HISTORY FORM

Name: \_\_\_\_\_ M/F Date of birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Today's date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

SSN #: \_\_\_\_\_ Email address: \_\_\_\_\_

Responsible party: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Referred by/Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

## Patient Past Medical History:

YES	NO	High blood pressure	YES	NO	Asthma
YES	NO	Congestive heart failure	YES	NO	Emphysema/chronic bronchitis
YES	NO	Heart attack	YES	NO	Thyroid disorder
YES	NO	Cancer, type _____	YES	NO	Radiation therapy
YES	NO	Depression	YES	NO	Kidney failure
YES	NO	Bleeding disorder	YES	NO	Diabetes (year of diagnosis: _____)
YES	NO	Hepatitis/liver disease	YES	NO	Insulin
YES	NO	Sleep apnea (CPAP yes/no)			
YES	NO	Have you taken any diet pills in the past two weeks?			
YES	NO	Have you taken or are you currently taking aspirin or aspirin products in the past two weeks?			
YES	NO	Have you taken or are you currently taking steroids (e.g. Prednisone) in the past two weeks?			
YES	NO	Are you taking any blood thinners (Coumadin or Warfarin)?			
YES	NO	Are you taking any diuretics or water pills?			

Other Medical Concerns: \_\_\_\_\_

## FAMILY MEDICAL HISTORY (Please list family members)

Cancer (and type): \_\_\_\_\_

Heart Disease: \_\_\_\_\_

Diabetes: \_\_\_\_\_

**SOCIAL HISTORY:** (Please circle) Alcohol Yes No Illicit drugs Yes No  
Tobacco Yes No Packs per day \_\_\_\_\_ years \_\_\_\_\_

**EMPLOYER/OCCUPATION:** \_\_\_\_\_ **MARITAL STATUS:** S M D W

Do you have any drug allergies or reactions to medications? Please list drug and reaction(s) (hives, etc) \_\_\_\_\_

## CURRENT MEDICATIONS (including herbal and over-the-counter): You may provide a list for your convenience

Name	Dose	Frequency	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____