

Patient History Form						
Name: Birth date:						
Marital Status:	Occupation:					

Allergies to Medications, Latex or Dyes	□None □ Yes (please list)

Medications (Prescriptions, non-prescriptions, vitaming	□None □ Yes (please list)	

Surgeries/Hospitalizations/Serious Injuries	Year

Immunizations	Ν	Y		Ν	Y
Hepatitis B Series			Recent Pneumonia Vaccine		
Gardasil Series			Recent Flu Vaccine		
Chicken Pox immunization or disease			Positive TB Screening		

Health Maintenance No Yes(Year)No Yes(Year)								(Year)
Colonoscopy					Bone Density			
Mammogram					Eye Exam			
Pap Smear					Physical Exam			

Social History	No	Yes	
Smoking			Pack(s)/day /years
Alcohol			Drinks/day drinks/week
Caffeine			Drinks/day
Recreational Drugs			
Special Diet			If yes describe:
Regular Exercise			If yes describe:
Sexually Active			□ Men □ Women □ Both

GYN History	OB History
Age of first mensus: () Menopause \Box N \Box Y (if yes Age:)	Total Number of Pregnancies:()
Regular Periods 🗆 N 🗆 Y Painful Periods 🗆 N 🗆 Y	Full Term () Pre Term ()
PMS \Box N \Box Y – if yes describe	Miscarriages () Abortions ()
Abnormal Pap: – if Yes approximate date ()	Tubal ()
Pain with intercourse: \Box N \Box YContent	with sex life: $\Box N \Box Y$

ENT	GENITOURINARY	SKIN
Eye Problems	Urinary Infections	Psoriasis
Sinus Problems	Kidney Disease/Stones	Skin Disorders
Hearing Loss	Erectile Dysfunction	Melanoma
	STD	
CARDIOVASCULAR	Urinary Incontinence	
Abnormal EKG	MUSCULOSKELETAL	PSYCH
Chest Pain	Arthritis/Osteo	ADD/ADHD
Heart Attack	Arthritis/Rheumatoid	Anxiety
Heart Disease	Gout	Depression
High Blood Pressure	Neck/Spinal Problems	Memory Loss
High Cholesterol	NEUROLOGICAL	OCD
Stroke	Concussion	Suicidal Thoughts/attempt
Peripheral Vascular Disease	Headaches	
PULMONARY	Migraines	
Asthma	Epilepsy/Seizures	
Emphysema/COPD	HEMATOLOGICAL	
Shortness of Breath	Anemia	
Sleep Apnea	Bleeding Disorders	
GASTROINTESTINAL	Blood Clots	
Acid Reflux	Cancer	
Constipation	Sickle Cell Disease	
Diarrhea	ENDOCRINE	
Irritable Bowel	Diabetes	
Gall Bladder Disease	Thyroid Disease	
Hernia	Pancreatitis	
Liver Disease		

Medical History (please check if positive)

Family History (please check all applicable boxes)

Illness	Father	Mother	Sibling	Child	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Other
					G-mother	G-father	G-mother	G-father	
Asthma									
Bleeding Disorders									
Breast Cancer									
Colon Cancer									
Depression/Anxiety									
Diabetes									
Drug/Alcohol Addiction									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Leukemia									
Liver Disease									
Lung Cancer									
Osteoporosis									
Ovarian Cancer									
Pancreatic Cancer									
Rheumatoid Arthritis									
Stroke									
Thyroid Disease									
Other:									