



Patient History Form

Today's Date: ____/____/____		
NAME: _____	Date of Birth: ____/____/____	
Last	First	M. I.
Age: _____ Sex: <input type="checkbox"/> F <input type="checkbox"/> M		
How did you hear about this clinic?		
Describe briefly the reason for your visit		

CURRENT MEDICATIONS		
Drug allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes To what?		
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other medical conditions (please list):

_____**PERSONAL HISTORY**

Were there problems with your birth? (specify) _____

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

What is your current or past occupation? _____ How many hours per week? _____

Are you ☐ retired ☐ disabled ☐ sick leave, how long? _____

List all hospitalizations and/ or surgeries: _____

List all drug allergies: _____

FAMILY HISTORY**IF LIVING**

(heart disease, stroke, cancer, diabetes, etc.)

IF DECEASED

	Age (s)	Health or Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL

- ☐ Recent weight gain; how much _____
- ☐ Recent weight loss: how much _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES

- ☐ Numbness
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling

Where?

EARS

- ☐ Ringing in ears
- ☐ Loss of hearing

EYES

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness

THROAT

- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw

HEART AND LUNGS

- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Swollen legs or feet
- ☐ Cough

NERVOUS SYSTEM

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling
- ☐ Memory loss

STOMACH AND INTESTINES

- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

SKIN

- ☐ Redness
- ☐ Rash
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet

BLOOD

- ☐ Anemia
- ☐ Clots

KIDNEY/URINE/BLADDER

- ☐ Frequent or painful urination
- ☐ Blood in urine

Women Only:

- ☐ Abnormal Pap smear
- ☐ Irregular periods
- ☐ Bleeding between periods
- ☐ PMS

PSYCHIATRIC

- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulties with sexual arousal
- ☐ Poor appetite
- ☐ Food cravings
- ☐ Frequent crying
- ☐ Sensitivity
- ☐ Thoughts of suicide / attempts
- ☐ Stress
- ☐ Irritability
- ☐ Poor concentration
- ☐ Racing thoughts
- ☐ Hallucinations
- ☐ Rapid speech
- ☐ Guilty thoughts
- ☐ Paranoia
- ☐ Mood swings
- ☐ Anxiety
- ☐ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

Patient/Guardian Signature: _____

Date: _____

Relationship if not the patient: _____