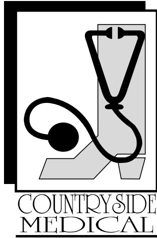

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PATIENT HISTORY FORM

NAME ____________________ DATE: __________

Have you ever had or do you now have any of the following? Please answer all items.

Fatigue	____	Mini Stroke	____	Heart Attack	____	**Males Only:**	
Anemia (low blood)	____	Chronic Cough	____	Stroke	____	Difficulty Starting Stream	____
German Measles	____	Coughing Blood	____	Kidney Stones	____	Discharge from Penis	____
Rheumatic Fever	____	Pleurisy/Pneumonia	____	Blood in Urine	____	Slowing of Urinary Stream	____
Swollen/Painful Joints	____	Pain or Pressure in Chest	____	Arthritis/Rheumatism	____	Decreased Sex Drive	____
Mumps	____	Palpitations	____	Bursitis	____	Venereal Disease	____
Frequent Headaches	____	High/Low Blood Pressure	____	Frequent Backache	____	**Females Only:**	
Dizziness of Fainting	____	Leg Cramps	____	Paralysis or Double Vision	____	Vaginal Discharge	____
Eye Trouble	____	Heart Murmur	____	Seizures or Convulsions	____	Painful Periods	____
Nose Bleeds	____	Swelling of Feet and Hands	____	Numbness or Tingling	____	Vaginal Itching	____
Decreased Hearing	____	Frequent Indigestion	____	Frequent Trouble Sleeping	____	Bleeding after Intercourse	____
Ringing in Ears	____	Abdominal Pain	____	Depression or Anxiety	____	Menopause	____
Ear Infections	____	Ulcers	____	Kidney/Bladder Infections	____	Hormone Therapy	____
Chronic or recurrent colds	____	Belching or Gas	____	Loss of Memory/Amnesia	____	Decreased Sex Drive	____
Severe tooth/gum trouble	____	Constipation or Diarrhea	____	Nervous Trouble	____	Abnormal Pregnancy	____
Sinusitis/Post Nasal Drip	____	Change in Bowel Habits	____	Puffiness of the Eyes	____	Miscarriages	____
Hay Fever/Asthma	____	Rectal Bleeding/Pain/Itching	____	Perspire or feel cold easily	____	Irregular Periods	____
Goiter	____	Vomiting Blood/Black Stools	____	Excessive or poor appetite	____	Decrease of Periods	____
Tuberculosis	____	Jaundice/Gallbladder Disease	____	Recent weight gain or loss	____	Female Periods	____
Soaking Sweats/Fever	____	Tumor/Growth Cysts	____	Get up Nights to Urinate	____	Date of Last Period	____
Difficulty Swallowing	____	Rupture/Hernia	____	Bleeding gums/easily bruise	____	**Quantity**	____
Hoarseness/Wheezing	____	Frequent or Painful Urination	____	Skin rashes, lumps or moles	____	Normal ____	Heavy ____
Shortness of Breath	____	Allergies	____	Cancer	____	Light ____	

SOCIAL HISTORY

Do you drink alcohol? __________

If yes, how many drinks per week? __________

Do you use or have used tobacco in any form? __________

If yes, what form? __________

For how long? __________ Pack per day __________

Have you quit __________ If so, when? __________

Are you allergic to any medications? __________

If yes, explain: __________

Do you have any difficulty taking medications or following drug instructions? __________

If yes, explain: __________

FAMILY HISTORY

Relation:	Living?/Age/Health Status	Deceased?/Cause/Age
Father	Y/N ____	Y/N ____
Mother	Y/N ____	Y/N ____
Brother(s)	Y/N ____	Y/N ____
Sister(s)	Y/N ____	Y/N ____
Children	Y/N ____	Y/N ____

Has anyone in your family had any of the following?

	No	Yes	Relation
Asthma, hay fever	____	____	____
Tuberculosis	____	____	____
Diabetes	____	____	____
Cancer	____	____	____
Kidney Trouble	____	____	____
Heart Trouble	____	____	____
Stomach Trouble	____	____	____
Rheumatism	____	____	____
High Blood Pressure	____	____	____
Mental Condition	____	____	____

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