



Patient History Form

Date: _____

Name: _____ DOB: _____ Age: _____

Address: _____ S. S.# _____

City: _____ State: _____ Zip: _____

Phone: Hm: _____ Wk: _____ Cell: _____

Spouse Ph: _____ WK: _____ Cell: _____

Emergency Contact: _____ Ph: _____

Please list all Doctors involved in your care including referring physician and Primary Care Physicians.

Name	Address	Phone#
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What problem brought you to our clinic? _____

Did you have surgery or a biopsy for this? _____

Did you have chemotherapy or hormone therapy? _____

Have you ever had radiation therapy? _____ If yes, When and Where?

Martial Status: Single _____ Married _____ Divorced _____ Widowed _____

Number of Children: _____ Ages: _____

Occupation: _____ Highest Level of Education: _____

Do you have assistance at home to help with daily living activities? _____

Do you have an out of Hospital Do-Not-Resuscitate Order? _____

If yes, please provide a copy for your chart or understand that a HOSPITAL DNR will not be honored.

MEDICAL HISTORY

Allergies: (include drug, food, iodine contrast agents)

Current Medications: (prescriptions meds, over the counter, herbal, vitamins)

Past Hospitalizations and Surgeries (include year):

Have you ever used hormones? _____

Do you or did you smoke? _____ When did you quit? _____

How many packs a day? _____ For how many years? _____

Other tobacco use? _____ If yes, list type _____

Do you drink alcohol? _____ How much? _____

Do you wear dentures? _____ If yes, full or partial? _____

Do you wear glasses? _____ Contacts? _____ Hearing Aid? _____

Do you have a history of any of these? (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Chron's Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Colitis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Asthmas | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Anemia |

Any other Medical Problem? _____

Has anyone in your family had Cancer? (List who and what type)

Do you have any of these symptoms? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Lumps |
| <input type="checkbox"/> Blood in Sputum | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Unusual Bleeding |

Any other symptoms? _____

Patient's Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____