# Patient History Form

Please complete the following form and answer all questions so that we may have an accurate record of your medical history. Thank you.

Chart #:

Today's Date:

**Name:** **Date of Birth:** **Referring Physician:**

| **Allergy to:** | | **Reaction** |
|---|---|---|
| **Latex** | Yes ☐ No ☐ | |
| **Shellfish** | Yes ☐ No ☐ | |
| **X-Ray Dye** | Yes ☐ No ☐ | |
| **Iodine** | Yes ☐ No ☐ | |

| **Current Medications, Vitamins & Minerals** ☐ **NONE** | **Dose** | **Frequency** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| **Drug Allergies:** ☐ **NONE** | **Reaction** |
|---|---|
| | |
| | |

**List current Pharmacy:**

Name:

Location:

Phone:

| **Past Medical Problems:** | **YES** | **NO** |
|---|---|---|
| Heart Disease | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Defibrillator | ☐ | ☐ |
| Lung Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Bowel Problems | ☐ | ☐ |
| Stroke/Seizure | ☐ | ☐ |
| Kidney Problems | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ |
| HIV | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |
| Cancer | ☐ | ☐ |

| **Questions:** | |
|---|---|
| **All Patients**: Have you had a flu vaccination in the current flu season? | Yes ☐ No ☐ **MM/YY:** |
| **All Patients**: Have you been hospitalized in the last 30 days? (Not Emergency Room) | Yes ☐ No ☐ |
| **Adults 65 years or older:** Have you had a Pneumonia Vaccinations in the last 12 months? | Yes ☐ No ☐ |
| **All Patients**: Have you had a fall within the last 2 years or problems with your gait or balance? | Yes ☐ No ☐ |
| **Women ages 50-74**: Have you had a Mammogram in the last 2 years? | Yes ☐ No ☐ |

**Social History**

**Current Smoker? (e-cig./vape)** Yes ☐ No ☐

**Previous Smoker? (e-cig./vape)** Yes ☐ No ☐

**Do you Drink Alcohol?**

| | |
|---|---|
| No | ☐ |
| Monthly or less | ☐ |
| 2 to 4 times a month | ☐ |
| 2 to 3 times a week | ☐ |
| 4 or more times a week | ☐ |

| **Recent Symptoms** | | |
|---|---|---|
| Unexplained Weight Loss | Yes ☐ | No ☐ |
| Dry Eyes | Yes ☐ | No ☐ |
| Dry Mouth | Yes ☐ | No ☐ |
| Leg Swelling | Yes ☐ | No ☐ |
| Shortness of Breath | Yes ☐ | No ☐ |
| Constipation | Yes ☐ | No ☐ |
| Involuntary Urine Loss | Yes ☐ | No ☐ |
| Lower Extremity Weakness | Yes ☐ | No ☐ |
| Dry Skin | Yes ☐ | No ☐ |
| Difficulty Walking | Yes ☐ | No ☐ |
| Psychiatric Problems | Yes ☐ | No ☐ |
| Impaired Sex Drive | Yes ☐ | No ☐ |
| Easy Bleeding | Yes ☐ | No ☐ |
| Rash | Yes ☐ | No ☐ |

| **Family History :** ☐ **Unknown** | | |
|---|---|---|
| Kidney Cancer | Yes ☐ | No ☐ |
| Kidney Problems | Yes ☐ | No ☐ |
| Kidney Stones | Yes ☐ | No ☐ |
| Prostate Cancer | Yes ☐ | No ☐ |
| If so, any of these immediate relatives? | | |
| Father | Yes ☐ | No ☐ |
| Brother | Yes ☐ | No ☐ |
| Son | Yes ☐ | No ☐ |
| Breast Cancer | Yes ☐ | No ☐ |
| If so, any of these immediate relatives? | | |
| Mother | Yes ☐ | No ☐ |
| Sister | Yes ☐ | No ☐ |
| Daughter | Yes ☐ | No ☐ |

| **♦Female Patients only: (Family History)** | | |
|---|---|---|
| Ovarian Cancer | Yes ☐ | No ☐ |
| Uterine Cancer | Yes ☐ | No ☐ |
| Cervical Cancer | Yes ☐ | No ☐ |

| **Past Surgeries:** ☐ **NONE** | |
|---|---|
| Kidney Surgery | ☐ |
| Lithotripsy | ☐ |
| Kidney Stone Surgery | ☐ |
| Bladder Surgery | ☐ |
| Bladder Tumor Removal | ☐ |
| Prostate Biopsy | ☐ |
| Prostatectomy | ☐ |
| Prostate Surgery | ☐ |
| Joint Replacement Surgery | ☐ |
| Open Heart Surgery | ☐ |
| Heart Valve Surgery | ☐ |
| Heart Stent Procedure | ☐ |
| Colon Surgery | ☐ |
| Gallbladder Surgery | ☐ |
| Hernia Repair | ☐ |
| Cataract Surgery | ☐ |
| C-Section | ☐ |
| Cystocele (Drop Bladder) | ☐ |
| D & C | ☐ |
| Ectopic Pregnancy | ☐ |
| Hysterectomy | ☐ |
| Laparoscopy | ☐ |
| Cervical Leep Conization | ☐ |
| Ovaries Removed (Both) | ☐ |
| Ovary Removed (One) | ☐ |
| Rectocele Repair | ☐ |
| Tubal Ligation | ☐ |
| Uterine Ablation | ☐ |
| Vaginal Cancer Treatment | ☐ |
| Vasectomy | ☐ |
| Other Abdominal Surgery | ☐ |
| NONE listed above | ☐ |