Patient History

Patient Name: _____ Todays Date:_____

Age:_____ Date of Birth:_____ Sex: **M F** Family Physician:_____

Marital Status: ☐ Single ☐ Married_____yrs. ☐ Divorced_____yrs. ☐ Widowed_____yrs.

Occupation:_____ Employer:_____

☐ Currently Employed ☐ Retired - If retired, date of last employment:_____

Highest Level of Education:_____ Hobbies:_____

Reason For Today's Visit:

_____

_____

Past Medical History:

_____

_____

Prior Accidents or Trauma: (include year and type of injury)

_____

_____

_____

Major Illness Requiring Hospitalization:

_____

_____

_____

Surgery: (give year/location/surgeon if you remember)

_____

_____

_____

Social History

Smoke? ☐ **No** ☐ **Yes**_____pack per day

Drink? ☐ **No** ☐ **Yes**_____drinks per day

Caffeine? ☐ **No** ☐ **Yes**_____drinks per day

Medications: (list all current and recent medications. If you have a list we will copy it for you)

_____

_____

Family History

List your Mother and Father's current illness (if any) or cause and year/age of their death:

Mother:_____

Father:_____

Review of Symptoms: Check any items below that may apply:

General		Brain	Lung/Cardio/Vascular	GI/Liver/URO	Muscular/Skeletal
☐ Weight Loss	☐ Weakness	☐ Headache	☐ Chest Pain	☐ Nausea/Vomiting	☐ Osteoporosis
☐ Weight Gain	☐ Numbness	☐ Stroke	☐ Palpitations	☐ Diarrhea	☐ Back Pain
☐ Cold/Hot Intolerance	☐ Imbalance	☐ TIA	☐ High Blood Pressure	☐ Constipation	☐ Neck Pain
☐ Rash/Hives	☐ Visual Change	☐ Seizures	☐ Heart Attack	☐ Blood in Urine/Stool	☐ Hip Pain
☐ Bleed Easily	☐ Depression	☐ Alzheimer's	☐ Snoring/Sleep Apnea	☐ Incontinence	☐ Joint Pain/Swelling
☐ Bruise Easily	☐ Anxiety	☐ Memory Difficulty	☐ Difficulty Sleeping	☐ Urinary Problems	
☐ Fever	☐ Drug Abuse	☐ Nervous Breakdown	☐ Cough	☐ Ulcer	
☐ Fatigue	☐ Loss Of Energy		☐ Asthma		
☐ Suicide Attempt					
☐ Blood Transfusion	Other:_____	Other_____	Other:_____	Other:_____	Other:_____