**Comprehensive Patient History Form** Date: Name: D.O.B.

**Past Medical History**: *(check all that apply)*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ☐ | Acid Reflux | ☐ | Cataracts | ☐ | Heart disease | ☐ | Migraines |
| ☐ | Alcohol or Drug Problem | ☐ | Colitis/Crohns | ☐ | Heart valve problems | ☐ | Mental Health Diagnosis |
| ☐ | Allergy problems | ☐ | Chronic pain | ☐ | Hernia | ☐ | MRSA |
| ☐ | Anemia | ☐ | Depression, Anxiety | ☐ | High blood pressure | ☐ | Osteoporosis |
| ☐ | Artery/Vein problems | ☐ | Diabetes | ☐ | High cholesterol | ☐ | Recurrent skin infections |
| ☐ | Arthritis | ☐ | Esophagitis, ulcers | ☐ | HIV | ☐ | Recurrent UTI |
| ☐ | Asthma | ☐ | Fractures | ☐ | Irritable bowel | ☐ | Seizures |
| ☐ | Autoimmune disease | ☐ | Gallstones | ☐ | Kidney disease | ☐ | Sexually transmitted Infections |
| ☐ | Bleeding problems | ☐ | Glaucoma | ☐ | Kidney stones | ☐ | Sleep Apnea |
| ☐ | Blood clots | ☐ | Gout | ☐ | Liver disease/Hepatitis | ☐ | Stroke |
| ☐ | Cancer | ☐ | Headaches | ☐ | Lung disease | ☐ | TB |
|  |  |  |  |  |  | ☐ | Thyroid diseases |

Other diseases not listed above: Hospitalizations/Significant injuries:

**Surgery/Procedures History:** *(check all that apply)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ☐ | Appendix | ☐ | Heart Surgery | ☐ | Joint replacement/Orthopedic surgery |
| ☐ | Bladder Suspension |  | * Bypass
 | ☐ | Kidney surgery |
| ☐ | Blood vessel surgery |  | * Heart valve surgery
 | ☐ | Organ Transplant |
|  | * Arteries
 |  | * Angioplasty (balloon)
 | ☐ | Prostate surgery |
|  | * Veins
 |  | * Stents
 | ☐ | Thyroidectomy |
| ☐ | Colon/Rectal surgery |  | * Pacemaker
 | ☐ | Sinus surgery |
| ☐ | Dental surgery | ☐ | Hysterectomy | ☐ | Tonsils and/or adenoids |
| ☐ | Eye surgery |  | * Complete ☐ Partial
 | ☐ | Tubal Ligation |
| ☐ | Gallbladder | ☐ | Hernia | ☐ | Vasectomy |

Other surgery not listed above:

* Previous reaction to anesthesia: (explain)

Please list the names of other practitioners you have or are currently seeing:

DOB

Patient Name

**Medication List:**

Please list **all** prescription and non-prescription medications. This includes vitamins, herbal medicine, supplements, birth control pills, inhalers and over the counter medications.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **How often** | **Disease or Reason** | **Prescribed by** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

List all medications you have stopped taking in the last 12 months:

# Allergies or reactions:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication/Food/Environmental** | **Reaction** | **Medication/Food/Environmental** | **Reaction** |
| **1.** |  | **2.** |  |
| **3.** |  | **4.** |  |
| **5.** |  | **6.** |  |

Preferred Pharmacy:

Name**:**

# Family History:

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Member** | **Age(s)** | **Living** | **Cause of Death** |
| Father |  |  |  |
| Mother |  |  |  |
| Brother(s) # |  |  |  |
| Sister(s) # |  |  |  |

**Diseases in the family:** *(check all that apply)*

|  |  |  |  |
| --- | --- | --- | --- |
| * Arthritis
 | * Cancer
 | * Depression/Anxiety
 | * High cholesterol
 |
| * Addiction problems
 | * Breast
 | * Diabetes
 | * Kidney disease
 |
| * Bleeding problems
 | * Colon
 | * Heart disease
 | * Liver disease
 |
|  | * Prostate
 | * High blood pressure
 | * Mental Illness
 |
|  | * Other
 |  |  |

# Social History:

Do you live: Alone ☐ with Spouse or Partner ☐ with Family ☐ Other ☐

Who do you rely on for support and help?

Do you smoke? ☐ Currently ☐ Past ☐ Never packs/day for years Date quit: If you do smoke, are you interested in quitting? ☐ YES ☐ NO

Other nicotine use ☐ YES ☐ NO

Exposure to second hand smoke? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO ☐ Beer ☐ Wine ☐ Liquor How many drinks per week? How many caffeinated beverages per day? ☐ Coffee ☐ Tea ☐ Sodas ☐ Energy Supplements

Any recreational drug use? ☐ YES ☐ NO

Type:

Do you exercise regularly? ☐ YES ☐ NO If so how many times per week? Type of exercise: Do you feel safe in your home? ☐ YES ☐ NO

How many hours of sleep do you get per night? Do you wake feeling well rested? ☐ YES ☐ NO

# Preventative Care:

□

Date of last Colon and Rectal Screening:

Have you had a bone density (DEXA) exam? ☐ YES ☐ NO Date:

Date of last eye exam: Date of last dental exam:

# Immunizations Date Immunizations Date

|  |  |  |  |
| --- | --- | --- | --- |
| Tetanus |  | Hepatitis A |  |
| Influenza/Flu |  | Hepatitis B |  |
| Pneumonia |  | Shingles |  |
| Whooping Cough |  | HPV |  |

**For our FEMALE patients only:**

Date of last menstrual period:

Do you have a Gynecologist ☐ YES ☐ NO If yes, Gynecologist name: Date of last PAP test: Date of last mammogram:

Have you gone through menopause? ☐ YES ☐ NO

Menstrual problems: ☐ Irregular ☐ Heavy ☐ Change in frequency Number of pregnancies: Number of live births: Current birth control method:

**For our MALE patients only:** Date of last PSA test: Date of last rectal exam:

**For our Pediatric patients only:** (Please answer from the child’s perspective)

What is the current marital status of the child’s parents?

* Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐ Widower

Who does the child primarily reside with? ☐ Both parents ☐ Mother ☐ Father ☐ Other:

Does the child have siblings? ☐ Yes ☐ No

If yes, # of brothers # of sisters

Does the child attend daycare? ☐ Yes

No

If yes, average # of days per week

If school age, current grade in school