

## PATIENT HISTORY

Primary MD \_\_\_\_\_  
 Phone# \_\_\_\_\_  
 Fax # \_\_\_\_\_

NAME \_\_\_\_\_  
 DOB \_\_\_\_\_ PHONE NO (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_  
 RELIGION (Optional) \_\_\_\_\_ MARITAL STATUS:  Single  Married  Divorced  Widow/  
 OCCUPATION \_\_\_\_\_ PREVIOUS OCCUPATIONS \_\_\_\_\_  
 OCCUPATION OF SPOUSE \_\_\_\_\_ BIRTH PLACE \_\_\_\_\_

LIST ALL STATES OR COUNTRIES WHICH YOU HAVE LIVED IN \_\_\_\_\_  
 EDUCATION: Please circle the last grade completed GRADE 5 6 7 8 HIGH 1 2 3 4 COLLEGE 1 2 3 4

REASON FOR TODAY'S APPOINTMENT \_\_\_\_\_  
 WERE YOU REFERRED TO THE CLINIC?  Yes  No IF SO, BY WHOM? \_\_\_\_\_  
 ARE THERE ANY CULTURAL NEEDS THAT AFFECT YOUR HEALTHCARE?  Yes  No PRIMARY LANGUAGE \_\_\_\_\_

### PERSONAL HISTORY (PLEASE CIRCLE YES OR NO)

**HAVE YOU EVER HAD ANY OF THE FOLLOWING:**

<p>Measles or German Measles      Yes    No</p> <p>Chicken Pox                            Yes    No</p> <p>Whooping Cough                      Yes    No</p> <p>Scarlet Fever or Scarletina        Yes    No</p> <p>Migraine Headaches                 Yes    No</p> <p>Stroke or Paralysis                 Yes    No</p> <p>Blindness (even temporary)        Yes    No</p> <p>Seizures or Epilepsy                Yes    No</p> <p>Meningitis                             Yes    No</p> <p>Pneumonia or Pleurisy               Yes    No</p> <p>Tuberculosis                          Yes    No</p> <p>Asthma                                 Yes    No</p> <p>Influenza or flu                        Yes    No</p> <p>Hay Fever                              Yes    No</p> <p>Hives or Eczema                        Yes    No</p> <p>Heart Attack                            Yes    No</p> <p>Angina                                 Yes    No</p> <p>Heart Failure                          Yes    No</p> <p>Rheumatic Fever or Heart Murmur    Yes    No</p> <p>High Blood Pressure                 Yes    No</p> <p>High Cholesterol                      Yes    No</p> <p>Diabetes                                Yes    No</p> <p>Thyroid Disease                        Yes    No</p>	<p>Hiatal Hernia or Reflux              Yes    No</p> <p>Ulcers (stomach or intestinal)        Yes    No</p> <p>Hepatitis or Jaundice                Yes    No</p> <p>Gallbladder Disease                 Yes    No</p> <p>Diverticulosis                        Yes    No</p> <p>Kidney Stones/Kidney Failure        Yes    No</p> <p>Bright's Disease                        Yes    No</p> <p>Kidney/Urinary Tract Infection      Yes    No</p> <p>Venereal Disease (Type _____) Yes    No</p> <p>Gonorrhea or Syphilis                Yes    No</p> <p>HIV Infection                         Yes    No</p> <p>Arthritis or Rheumatism              Yes    No</p> <p>Bursitis, Sciatica, Lumbago         Yes    No</p> <p>Anemia                                 Yes    No</p> <p>Unusual Bleeding or Bruising        Yes    No</p> <p>Poisoning (food, drugs, chemicals)    Yes    No</p> <p>Radiation Therapy/Chemotherapy    Yes    No</p> <p>Cancer (Type _____)            Yes    No</p> <p>Nervous Breakdown                    Yes    No</p> <p>Severe Depression                    Yes    No</p> <p>Frequent Sore Throat                 Yes    No</p> <p>Frequent Infections                 Yes    No</p> <p>Any Other Disease (Type _____) Yes    No</p> <p>If yes please list: _____</p>
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FAMILY HISTORY	AGE IF LIVING/ HEALTH	AGE AT DEATH/ CAUSE OF DEATH	HAS ANY BLOOD RELATIVE EVERY HAD	
FATHER:			CANCER	YES NO
MOTHER:			TUBERCULOSIS	YES NO
BROTHERS OR SISTERS:			DIABETES	YES NO
			HEART DISEASE	YES NO
			HIGH BLOOD PRESSURE	YES NO
			STROKE	YES NO
			EPILEPSY	YES NO
HUSBAND/WIFE			MENTAL ILLNESS	YES NO
SON/DAUGHTER			SUICIDE	YES NO
			THYROID	YES NO
			ALCOHOLISM	YES NO
			LUPUS	YES NO
			OTHER ILLNESS	YES NO

**PLEASE LIST IMMEDIATE FAMILY MEMBERS WHO HAVE OR HAVE HAD CANCER OR A BLOOD DISORDER.**

<u>FAMILY MEMBER</u>	<u>CANCER/BLOOD DISORDER</u>	<u>FAMILY MEMBER</u>	<u>CANCER/BLOOD DISORDER</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

NAME \_\_\_\_\_

DOB \_\_\_\_\_

Primary MD \_\_\_\_\_

PHONE NO (\_\_\_\_) \_\_\_\_\_

Phone# \_\_\_\_\_

Fax # \_\_\_\_\_

**WOMEN ONLY:**

Age at onset of menstruation \_\_\_\_\_

Date of last period \_\_\_\_\_

Is it possible you may be pregnant? \_\_\_\_\_

Menstrual cycle \_\_\_\_\_ days from start to finish \_\_\_\_\_

Cycle: \_\_\_\_\_ regular \_\_\_\_\_ irregular

Usual duration of flow \_\_\_\_\_ days

Flow: \_\_\_\_\_ Heavy \_\_\_\_\_ Medium \_\_\_\_\_ Light

Pregnancies: How Many? \_\_\_\_\_

Children Born Alive? \_\_\_\_\_

Miscarriages? \_\_\_\_\_

Stillbirth? \_\_\_\_\_

Prematures? \_\_\_\_\_

Cesarean sections? \_\_\_\_\_

Complications? \_\_\_\_\_

**HAVE YOU EVER BEEN IMMUNIZED FOR (CIRCLE YES/NO)**

Diphtheria Yes No When? \_\_\_\_\_

Tetanus Yes No When? \_\_\_\_\_

Polio Yes No When? \_\_\_\_\_

German Measles Yes No When? \_\_\_\_\_

Have you had a skin

test for TB (Tuberculosis) Yes No When? \_\_\_\_\_

Results \_\_\_\_\_

Pneumonia Yes No When? \_\_\_\_\_

Influenza Yes No When? \_\_\_\_\_

Measles Yes No When? \_\_\_\_\_

Whooping Cough Yes No When? \_\_\_\_\_

**ALLERGIES: (ARE YOU ALLERGIC TO)**

Penicillin or Keflex Yes No

Sulfa Yes No

Erythromycin or Tetracycline Yes No

Levaquin or Cipro Yes No

Any other antibiotics Yes No

If yes please list \_\_\_\_\_

Aspirin or Tylenol Yes No

Codeine, Morphine, Demerol Yes No

Any other pain medication Yes No

Valium or Librium Yes No

Any other tranquilizers or sleeping meds. Yes No

Iodine, Merthiolate, or Mercurochrome Yes No

Betadine Yes No

Antihistamines Yes No

Any other drug \_\_\_\_\_ Yes No

Any Food Yes No

Adhesive Tape Yes No

Cosmetics or Perfume Yes No

Nail Polish Yes No

Tetanus antitoxin Yes No

Any other immunizations Yes No

Any other Serums Yes No

**PLEASE LIST ANY ALLERGIES NOT LISTED:** \_\_\_\_\_

**INJURIES: HAVE YOU HAD ANY OF THE FOLLOWING**

Broken Bones Yes No

Sprains or Dislocations Yes No

Lacerations (Extensive) Yes No

Concussion or head injury Yes No

“Whiplash” Yes No

**HAVE YOU EVER HAD BLOOD OR PLASMA TRANSFUSION?** Yes No

**WEIGHT NOW:** \_\_\_\_\_

**ONE YEAR AGO:** \_\_\_\_\_

**MAXIMUM:** \_\_\_\_\_

**SURGERY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOSPITALIZATIONS OTHER THAN SURGERY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU EVER HAD A BLEEDING COMPLICATION DOSE FROM A SURGICAL PROCEDURE:** Yes No

**MEDICATIONS: PLEASE LIST ALL MEDICATION AND THAT YOU TAKE.**

**HABITS:**

Do you sleep well? Yes No

Use alcoholic beverages? Yes No

Every day? Yes No

Smoke? Yes No

How much? \_\_\_\_\_ Yes No

Exercise? Yes No

Is your diet well balanced? Yes No

Any known risk for HIV infection? Yes No

Any known exposure to Asbestos? Yes No

Do you have any pets? Yes No

**SEE MEDICATION RECONCILIATION FORM**

PATIENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_