

**PATIENT HISTORY FORM**

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_      DATE OF LAST PHYSICAL EXAM \_\_\_\_/\_\_\_\_/\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

SOCIAL SECURITY No. \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_      AGE \_\_\_\_\_

OCCUPATION. \_\_\_\_\_ MARITAL STATUS    MARRIED     SINGLE     DIVORCED     WIDOWED

**Medical** (*High Blood Pressure, Diabetes, Asthma, Cancer, Heart Disease, etc.*)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Surgical** (*Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.*)  None

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies** to medications?  None (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

\_\_\_\_\_

Current prescription medicines				Current prescription medicines			
Name of drug	mg dose	# tablets	# times per day	Name of drug	mg dose	# tablets	# times per day
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

**OTC medicines.** (*Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals.*)

\_\_\_\_\_

\_\_\_\_\_

**Family History**

Father:  Living - Age: \_\_\_\_\_  Deceased, Age at Death \_\_\_\_\_ (Cause) \_\_\_\_\_

Mother:  Living - Age: \_\_\_\_\_  Deceased, Age at Death \_\_\_\_\_ (Cause) \_\_\_\_\_

Siblings: Number Living \_\_\_\_\_ Number deceased \_\_\_\_\_ (Cause) \_\_\_\_\_

List other illnesses in your family (Example - Diabetes, heart disease, colon cancer, breast cancer, prostate cancer, etc)

Family Member	Illness	Family Member	Illness	Family Member	Illness
_____	_____	_____	_____	_____	_____

**Social History**

**Smoke?**  Yes  No    If yes, how much? \_\_\_\_\_ # of packs/day    \_\_\_\_\_ # of years    When did you stop smoking? \_\_\_\_\_

**Alcohol?**  Yes  No    If yes, how much? \_\_\_\_\_

**Exercise** regularly?  Yes  No    If yes, what and how frequently? \_\_\_\_\_

Routinely wear **seatbelts?**  Yes  No    Routinely wear a **helmet?**  Yes  No    Substance Abuse?  Yes  No