

# Patient History Form

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

In your own words tell us why you are here to see the doctor

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**Allergies:** List below or check here for  NONE

Name of Allergic Item	What happens if taken

## Medications

Name	Strength, Route, when taken, days

## Social/Family History

- |                                    |   |                                      |
|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Married   | <input type="checkbox"/> Employed         | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> Widowed   | <input type="checkbox"/> Retired          | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Occupation _____ | <input type="checkbox"/> Drug Use    |
| <input type="checkbox"/> Divorced  |   |                                      |

Person	#	Check if deceased	Known Illness or Disease
Father	1		
Mother	1		
Brothers	#		
Sisters	#		
Children Boys	#		
Children Girls	#		

# Patient History Form

Check Items that apply to you. Ask the staff for help if needed.

General
<input type="checkbox"/> Chills
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Fever
<input type="checkbox"/> Increased thirst
<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Sweating
<input type="checkbox"/> Weight Gain
<input type="checkbox"/> Weight Loss
Eyes
<input type="checkbox"/> Blindness
<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Double Vision
<input type="checkbox"/> Eye Pain
<input type="checkbox"/> Loss of Vision
<input type="checkbox"/> Vision Flashes
<input type="checkbox"/> Vision Halos
Ear, Nose, Throat, Mouth
<input type="checkbox"/> Bleeding Gums
<input type="checkbox"/> Dental Cavities
<input type="checkbox"/> Ear Pain
<input type="checkbox"/> Ear Ringing
<input type="checkbox"/> Ear Swishing
<input type="checkbox"/> Ear Throbbing
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Loss of Hearing
<input type="checkbox"/> Lump in Neck
<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Tongue Sores
Skin
<input type="checkbox"/> Bruising
<input type="checkbox"/> Discoloration
<input type="checkbox"/> Edema
<input type="checkbox"/> Flushing
<input type="checkbox"/> Lump
<input type="checkbox"/> Pain
<input type="checkbox"/> Rash
<input type="checkbox"/> Redness
<input type="checkbox"/> Sores
<input type="checkbox"/> Swelling
<input type="checkbox"/> Ulcer

Vascular
<input type="checkbox"/> Ankle Discoloration
<input type="checkbox"/> Cellulitis
<input type="checkbox"/> Deep Vein Clots
<input type="checkbox"/> Gangrene
<input type="checkbox"/> Leg Cramps at night
<input type="checkbox"/> Leg Heaviness
<input type="checkbox"/> Leg Pain with walking
<input type="checkbox"/> Leg Throbbing
<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Skin ulcers
<input type="checkbox"/> Varicose veins
Lung
<input type="checkbox"/> Blood in Sputum
<input type="checkbox"/> Cough
<input type="checkbox"/> Pain with breathing
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Sputum increase
Heart
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Fatigue with Exercise
<input type="checkbox"/> Irregular Heart Beat
<input type="checkbox"/> Jaw Pain
<input type="checkbox"/> Leg/Ankle Edema
<input type="checkbox"/> Leg/Ankle Swelling
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Rapid Heart beat
<input type="checkbox"/> Syncope/Fainting
Gastrointestinal
<input type="checkbox"/> Blood in Stool
<input type="checkbox"/> Bowel change
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Nausea
<input type="checkbox"/> Stomach Burning
<input type="checkbox"/> Stomach Pain
<input type="checkbox"/> Stomach Swelling
<input type="checkbox"/> Vomiting

Muscle/Bone/Joint
<input type="checkbox"/> Back Pain
<input type="checkbox"/> Joint Deformity
<input type="checkbox"/> Joint Fluid
<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Joint Swelling
<input type="checkbox"/> Leg Numbness
<input type="checkbox"/> Muscle Pain
<input type="checkbox"/> Neck Pain
Nerves
<input type="checkbox"/> Burning Feet
<input type="checkbox"/> Facial Numbness
<input type="checkbox"/> Fainting
<input type="checkbox"/> Loss of Memory
<input type="checkbox"/> Loss of Sensation
<input type="checkbox"/> Loss of Strength
<input type="checkbox"/> Numbness
<input type="checkbox"/> Seizures
<input type="checkbox"/> Tingling
GU
<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Burning Urine
<input type="checkbox"/> Frequent Urine
<input type="checkbox"/> Pain with Urine
Male/Female
<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Impotence
<input type="checkbox"/> Penile Sore
<input type="checkbox"/> Testicle Lump
<input type="checkbox"/> PSA annual
<input type="checkbox"/> Chest X-ray
<input type="checkbox"/> Colonoscopy in Past
<input type="checkbox"/> Current Pregnancy
<input type="checkbox"/> EKG
<input type="checkbox"/> Irregular Bleeding
<input type="checkbox"/> Mammogram Yearly
<input type="checkbox"/> Pap Smear Yearly
<input type="checkbox"/> Post-Menopausal
<input type="checkbox"/> Pre-Menopausal
<input type="checkbox"/> Depression
<input type="checkbox"/> Suicide

# Patient History Form

<input type="checkbox"/> Aneurysm, AAA
<input type="checkbox"/> AIDS
<input type="checkbox"/> Alcohol Dependence
<input type="checkbox"/> Anemia
<input type="checkbox"/> Aneurysm, Chest
<input type="checkbox"/> Angioplasty/Stent Leg Artery
<input type="checkbox"/> Angioplasty/Stent Carotid Artery
<input type="checkbox"/> Angioplasty/Stent Heart Artery
<input type="checkbox"/> Anorexia/Bulimia
<input type="checkbox"/> Aortic Valve
<input type="checkbox"/> Aorto Bifemoral Artery Bypass Legs
<input type="checkbox"/> Appendectomy
<input type="checkbox"/> Appendicitis
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Arthroscopy
<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain
<input type="checkbox"/> Bladder Repair
<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Bowel Obstruction
<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Bronchoscopy
<input type="checkbox"/> CABG and Valve
<input type="checkbox"/> Cancer Breast
<input type="checkbox"/> Cancer Colon
<input type="checkbox"/> Cancer Lung
<input type="checkbox"/> Cancer Ovary
<input type="checkbox"/> Cancer Uterus
<input type="checkbox"/> Carpal Tunnel
<input type="checkbox"/> Cataracts Right
<input type="checkbox"/> Cataracts Left
<input type="checkbox"/> Chest Tube
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Cholesterol
<input type="checkbox"/> Cholecystectomy
<input type="checkbox"/> Colonoscopy
<input type="checkbox"/> Colon Resection
<input type="checkbox"/> Compression Stockings

<input type="checkbox"/> Coronary Bypass
<input type="checkbox"/> Defibrillator
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dialysis Fistula/Graft
<input type="checkbox"/> Disc Removal, Lumbar
<input type="checkbox"/> Disc Removal, Neck
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Endovascular Aneurysm, EVAR
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Femoral Popliteal Artery Bypass
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Gallbladder
<input type="checkbox"/> Gastric/Peptic Ulcer
<input type="checkbox"/> GERD
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Goiter
<input type="checkbox"/> Headache
<input type="checkbox"/> Heart Aneurysm Surgery
<input type="checkbox"/> Heart Arrhythmia
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Heart Catheterization
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Pacemaker
<input type="checkbox"/> Heart Valve Disease
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hernia
<input type="checkbox"/> Hernia Repair, Groin
<input type="checkbox"/> Hernia Repair, Umbilical
<input type="checkbox"/> Herpes
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Hip Replacement
<input type="checkbox"/> HIV
<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Knee Replacement
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Lung Removal, Entire

<input type="checkbox"/> Lung Removal, Lobe
<input type="checkbox"/> Lupus
<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Measles
<input type="checkbox"/> Migraine
<input type="checkbox"/> Mitral Valve
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Mumps
<input type="checkbox"/> Ovary Removal
<input type="checkbox"/> Overweight
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> PAD, Artery Disease
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Prostate
<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Restless Legs
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Stent Leg Artery
<input type="checkbox"/> Stomach Resection
<input type="checkbox"/> Stroke
<input type="checkbox"/> Suicide
<input type="checkbox"/> Surgical Unlisted
<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> TIA
<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Tonsils/ Mouth Ulcers
<input type="checkbox"/> Urinary Infections
<input type="checkbox"/> Varicose Vein Laser or VNUS
<input type="checkbox"/> Varicose Vein Stripping
<input type="checkbox"/> Vein Injections, Sclerotherapy
<input type="checkbox"/> Wound Care

Other:

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