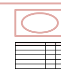
Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

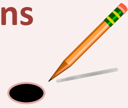
Patient History

Please answer every question.


STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

PERSONAL DATA

Age: ________

Do you have an Advanced Directive or Living Will?
If yes, please bring a copy for your provider. yes ◯ no ◯

Marital Status: single ◯ partnered ◯ divorced ◯ married ◯ separated ◯ widowed ◯

Occupation: ____________ **Social Security Number:** ____________

Home Phone #: ____________ **Work Phone #:** ____________

please fold on dotted line

WOMEN ONLY - OB/GYN HISTORY

Age period started: n/a ◯ under 8 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18 ◯ 19 ◯ 20 ◯ 21+ ◯

Length of cycle: ____________ **Date of last period:** ____________

Age period stopped: n/a ◯ under 42 ◯ 42 ◯ 43 ◯ 44 ◯ 45 ◯ 46 ◯ 47 ◯ 48 ◯ 49 ◯ 50 ◯ 51 ◯ 52 ◯ 53 ◯ 54 ◯ 55+ ◯

Have you ever used contraceptives? currently ◯ in the past ◯ never ◯

Are you pregnant or possibly pregnant? yes ◯ no ◯

Have you ever taken hormones? currently ◯ in the past ◯ never ◯

Do you have any of the following? (Mark all that apply.)
breast lump ◯ nipple discharge ◯ vaginal sores ◯ vaginal itching ◯ vaginal discharge ◯ bleeding between periods ◯ bleeding after intercourse ◯ prolonged, excessive periods ◯

PREGNANCY HISTORY

	0	1	2	3	4	5	6	7+
Number of pregnancies:	◯	◯	◯	◯	◯	◯	◯	◯
Number of live births:		◯	◯	◯	◯	◯	◯	◯
Number of stillbirths:		◯	◯	◯	◯	◯	◯	◯
Number of premature births:		◯	◯	◯	◯	◯	◯	◯
Number of miscarriages:		◯	◯	◯	◯	◯	◯	◯
Number of abortions:		◯	◯	◯	◯	◯	◯	◯
Number of C-sections:		◯	◯	◯	◯	◯	◯	◯

please fold on dotted line

ALLERGIES

Please mark all allergies that you have:

Medication Allergies

◯ **No Known MEDICATION Allergies**

◯ Amoxicillin
◯ Morphine
◯ Codeine
◯ Demerol
◯ Erythromycin
◯ Lortab
◯ Cephalosporins
◯ Oxycodone
◯ Penicillin
◯ Sulfa
◯ Tetracycline
◯ Tylenol
◯ NSAIDs (aspirin, ibuprofen, etc.)

Food Allergies

◯ **No Known FOOD Allergies**

◯ Eggs
◯ Fish
◯ Seafood
◯ Milk
◯ MSG
◯ Peanuts
◯ Nuts
◯ Soy
◯ Wheat
◯ Gluten

Environmental Allergies

◯ **No Known ENVIRONMENTAL Allergies**

◯ Bee Stings
◯ Dust Mites
◯ Animal Dander
◯ Adhesive Tape
◯ Iodine
◯ Mold
◯ Pollen
◯ Latex

◯ Seasonal Allergies (Ragweed)

OTHER (please specify): ____________

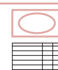
Licensed Under U.S. Patent Nos. 7,487,102 and 7,941,328 from Willis Technologies, LLC

Copyright © PatientLink Form 806 (Rev. 12/13/2013)

Patient name: ______________________

Patient History

Please answer every question.



STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

Have YOU or a FAMILY MEMBER had any of the following:

○ I Have NO CURRENT Medical Problems
○ I Have NO PAST Medical Problems
○ **Adopted** (Family History Unknown)
○ I Have NO FAMILY Medical History

YOU: CURRENTLY	YOU: IN THE PAST	FAMILY MEMBER: Father	Mother	Grandmother Mother's side	Grandfather Mother's side	Grandmother Father's side	Grandfather Father's side	Brother	Sister	
○	○	○	○	○	○	○	○	○	○	Anesthetic Complications
○	○	○	○	○	○	○	○	○	○	High Blood Pressure (Hypertension)
○	○	○	○	○	○	○	○	○	○	Diabetes
○	○	○	○	○	○	○	○	○	○	Chest Pain (Angina Pectoris)
○	○	○	○	○	○	○	○	○	○	Heart Attack
○	○	○	○	○	○	○	○	○	○	Irregular Heartbeat
○	○	○	○	○	○	○	○	○	○	High Cholesterol
○	○	○	○	○	○	○	○	○	○	Blood Clots
○	○	○	○	○	○	○	○	○	○	Anemia (Low Blood Count)
○	○	○	○	○	○	○	○	○	○	Stroke

please fold on dotted line

YOU: CURRENTLY	YOU: IN THE PAST	Father	Mother	Grandmother Mother's side	Grandfather Mother's side	Grandmother Father's side	Grandfather Father's side	Brother	Sister	
○	○	○	○	○	○	○	○	○	○	Emphysema / COPD
○	○	○	○	○	○	○	○	○	○	Asthma
○	○	○	○	○	○	○	○	○	○	Lung Nodules
○	○	○	○	○	○	○	○	○	○	Hepatitis B
○	○	○	○	○	○	○	○	○	○	Hepatitis C
○	○	○	○	○	○	○	○	○	○	Thyroid Nodules
○	○	○	○	○	○	○	○	○	○	Underactive Thyroid (Hypothyroidism)
○	○	○	○	○	○	○	○	○	○	Overactive Thyroid (Hyperthyroidism)
○	○	○	○	○	○	○	○	○	○	Osteoarthritis
○	○	○	○	○	○	○	○	○	○	Rheumatoid Arthritis
○	○	○	○	○	○	○	○	○	○	Kidney Stones
○	○	○	○	○	○	○	○	○	○	Ulcers (Bleeding)
○	○	○	○	○	○	○	○	○	○	Cataracts
○	○	○	○	○	○	○	○	○	○	Glaucoma
○	○	○	○	○	○	○	○	○	○	Positive Tuberculosis (TB) Skin Test
○	○	○	○	○	○	○	○	○	○	Anxiety
○	○	○	○	○	○	○	○	○	○	Bipolar
○	○	○	○	○	○	○	○	○	○	Schizophrenia
○	○	○	○	○	○	○	○	○	○	Depression
○	○	○	○	○	○	○	○	○	○	ADD
○	○	○	○	○	○	○	○	○	○	Colon Polyps

please fold on dotted line

YOU: CURRENTLY	YOU: IN THE PAST	Father	Mother	Grandmother Mother's side	Grandfather Mother's side	Grandmother Father's side	Grandfather Father's side	Brother	Sister	
○	○	○	○	○	○	○	○	○	○	Colon Cancer
○	○	○	○	○	○	○	○	○	○	Bladder Cancer
○	○	○	○	○	○	○	○	○	○	Skin Cancer
○	○	○	○	○	○	○	○	○	○	Breast Cancer
○	○	○	○	○	○	○	○	○	○	Lung Cancer
○	○	○	○	○	○	○	○	○	○	Pancreatic Cancer
○	○	○	○	○	○	○	○	○	○	Liver Cancer
○	○	○	○	○	○	○	○	○	○	Lymphoma (Lymph Cancer)
○	○	○	○	○	○	○	○	○	○	Leukemia
○	○	○	○	○	○	○	○	○	○	Thyroid Cancer
○	○	○			○		○	○		Prostate Cancer
○	○		○	○		○			○	Cervical Cancer
○	○		○	○		○			○	Ovarian Cancer
○	○		○	○		○			○	Uterine Cancer
○	○	○	○	○	○	○	○	○	○	Bone Cancer

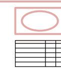
Licensed Under U.S. Patent Nos. 7,487,102 and 7,941,328 from Willis Technologies, LLC

Copyright © PatientLink Form 806 (Rev. 12/13/2013)

SAMPLE

Patient History

Please answer every question.



STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

SURGICAL HISTORY

Please indicate if YOU have had any of the following surgeries. Please provide DATE.

◯ **I Have Had NO SURGERIES**

DATE

◯ **Appendectomy** (Appendix) ____________________
◯ **Tonsillectomy** (Tonsils Removed) ____________________
◯ **Cholecystectomy** (Gallbladder Removed) ____________________
◯ **Hysterectomy** (Uterus Removed) ____________________
◯ **Heart Bypass Surgery** ____________________
◯ **Hemorrhoidectomy** (Hemorrhoids Removed) ____________________
◯ **Ovaries Removed** ____________________
◯ **Splenectomy** (Spleen Removed) ____________________
◯ **Colon Polyp Removal** ____________________
◯ **Colostomy** ____________________

please fold on dotted line

DATE

◯ **Pacemaker** ____________________
◯ **Defibrillator** ____________________
◯ **Coronary Artery Stent** ____________________

Cataract: ◯ Left ◯ Right ◯ Both ____________________

Colectomy (Colon Removal): ◯ Partial ◯ Total ____________________

Mastectomy: ◯ Left ◯ Right ◯ Both ____________________

Hernia Repair: ◯ Abdominal ◯ Belly Button (Umbilical) ◯ Incisional ____________________

Groin Hernia Repair (Inguinal): ◯ Left ◯ Right ◯ Both ____________________

OTHER (please specify surgery and date): ____________________

____

HEALTH MAINTENANCE PLAN

Please indicate when you last had each of the following applicable tests:

please fold on dotted line

	1 year ago or less	2 years ago	3 years ago	4 years ago	5 years ago	6 years ago	7 years ago	8 years ago	9 years ago	10 or more years ago
Colonoscopy	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Stool Test (Test for Blood in Stool)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Mammogram	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Bone Mineral Density Test	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pap Smear	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Prostate Exam	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Diabetic Eye Exam	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Glaucoma Screening	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Cholesterol Test	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Chest X-ray	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Dental Exam	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Periodic Health Exam	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Licensed Under U.S. Patent Nos. 7,487,102 and 7,941,328 from Willis Technologies, LLC

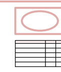
Copyright © PatientLink Form 806 (Rev. 12/13/2013)

SAMPLE

Patient name: ____________________

Patient History

Please answer every question.



STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

SOCIAL HISTORY

TOBACCO

What is your smoking status? current (every day) ◯ current (some days) ◯ previous ◯ never ◯

How many packs per day do you (or did you) **smoke?** less than 1 ◯ 1-2 ◯ more than 2 ◯

How many years have you (or did you) **smoke?** less than 5 ◯ 5 ◯ 10 ◯ 15 ◯ 20 ◯ 25 ◯ 30 ◯ 35 ◯ 40+ ◯

If you quit, how many years ago did you quit? less than 5 ◯ 5 ◯ 10 ◯ 15 ◯ 20 ◯ 25 ◯ 30 ◯ 35 ◯ 40+ ◯

Are you exposed to passive (secondhand) **smoke?** yes ◯ no ◯

ALCOHOL

Do you consume alcohol? currently ◯ in the past ◯ never ◯

If so, how much (now or in the past)? daily ◯ 4-6 times per week ◯ up to 3 times per week ◯ less than once per week ◯ social occasions ◯

please fold on dotted line

If you quit, how many years ago did you quit? less than 5 ◯ 5 ◯ 10 ◯ 15 ◯ 20 ◯ 25 ◯ 30 ◯ 35 ◯ 40+ ◯

DRUGS

Have you used recreational drugs? currently ◯ in the past ◯ never ◯

If so, how much (now or in the past)? daily ◯ 4-6 times per week ◯ up to 3 times per week ◯ less than once per week ◯

If you quit, how many years ago did you quit? less than 5 ◯ 5 ◯ 10 ◯ 15 ◯ 20 ◯ 25 ◯ 30 ◯ 35 ◯ 40+ ◯

CAFFEINE

Do you drink caffeinated beverages? currently ◯ in the past ◯ never ◯

If so, how much (now or in the past)? daily ◯ 4-6 times per week ◯ up to 3 times per week ◯ less than once per week ◯

EXERCISE

Do you exercise regularly? currently ◯ in the past ◯ never ◯

If yes, how much? daily ◯ 4-6 times per week ◯ up to 3 times per week ◯ less than once per week ◯

DEMOGRAPHICS

Race: American Indian / Alaska Native ◯ Asian ◯ Black / African American ◯ Native Hawaiian / Pacific Islander ◯ White / Caucasian ◯ Decline to answer ◯

Ethnicity: Hispanic or Latino ◯ Not Hispanic or Latino ◯ Decline to answer ◯

please fold on dotted line

Primary language: English ◯ Spanish ◯ **Other:** ____________________

DIET

If you are on a special diet, please describe:

____

TRAVEL

Have you recently traveled outside of the country? no ◯ yes ◯

If yes, where: ____________________

Do you live in more than one location throughout the year? no ◯ yes ◯

If yes, please remember to provide us with alternate contact and provider information.

Licensed Under U.S. Patent Nos. 7,487,102 and 7,941,328 from Willis Technologies, LLC

Copyright © PatientLink Form 806 (Rev. 12/13/2013)

SAMPLE