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

Please complete this history form. This will allow us to serve your health needs.
The information contained herein is strictly confidential and will not be released unless you authorize us to do so.

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following.
Mark all that apply. If none, mark, "**NO MEDICAL HISTORY**."

PAST	CURRENT		PAST	CURRENT	
○	○	Alcohol Abuse	○	○	Hyperthyroid (High Thyroid)
○	○	Allergies / Sinus	○	○	Hypothyroid (Low Thyroid)
○	○	Alzheimer's	○	○	Irritable Bowel Disease
○	○	Arthritis	○	○	Kidney Stones
○	○	Asthma	○	○	Liver Cancer
○	○	Bleeding Disease	○	○	Lung Cancer
○	○	Blood Clots	○	○	Lupus
○	○	Breast Cancer	○	○	Melanoma (Skin)
○	○	Bipolar Disorder	○	○	Multiple Sclerosis (MS)
○	○	Cervical Cancer	○	○	Osteoporosis
○	○	Cirrhosis (Liver Disease)	○	○	Ovarian Cancer
○	○	Colon Cancer	○	○	Pancreatic Cancer
○	○	Congestive Heart Failure	○	○	Parkinson's Disease
○	○	COPD / Emphysema	○	○	Peripheral Vascular Disease (PVD)
○	○	Coronary Artery Disease	○	○	Prostate Cancer
○	○	Crohn's Disease	○	○	Prostate Problems
○	○	Depression	○	○	Reflux / GERD
○	○	Diabetes Type 1	○	○	Rheumatic Fever
○	○	Diabetes Type 2	○	○	Rheumatoid Arthritis
○	○	Endocrine Tumors	○	○	Seizures / Convulsions
○	○	Glaucoma	○	○	Sexually Transmitted Disease (STD)
○	○	Gout	○	○	Sleep Apnea
○	○	Hearing Loss	○	○	Stomach Ulcer
○	○	Heart Attack	○	○	Stroke / CVA of the Brain
○	○	Hepatitis B	○	○	Suicide Attempt
○	○	Hepatitis C	○	○	Throat Cancer
○	○	High Blood Pressure	○	○	Tuberculosis (TB)
○	○	High Cholesterol	○	○	Ulcerative Colitis
○	○	HIV /AIDS		○	**NO MEDICAL HISTORY**

Other Disease, Cancer or Significant Medical Illness (please specify):

SOCIAL HISTORY

TOBACCO USE

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+ ○

Do you use other tobacco products? — currently ○ | in the past ○ | never ○

ALCOHOL USE

Do you consume alcohol? — currently ○ | in the past ○ | never ○

Average number of drinks per week (now or in the past)? — 7 or less ○ | 8-14 ○ | 15 + ○

DRUG USE

IV drug use or other recreational drug use? — currently ○ | in the past ○ | never ○

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SURGICAL HISTORY

Please mark all surgeries you have had:

- I'VE HAD NO SURGERIES
- Appendix Removal
- Breast Enhancement
- Breast Lumpectomy
- Breast Reduction
- Breast Removal
- Carotid Artery Surgery
- Cataract Surgery
- Colon Resection
- C-Section
- Ear Surgery
- Foot Surgery
- Gallbladder Surgery
- Heart Bypass Surgery
- Hernia Surgery
- Hysterectomy (due to cancer)
- Hysterectomy (not due to cancer)
- Kidney Removal
- Knee Surgery
- Low Back Disc Surgery
- Leg Bypass Surgery
- Liver Resection
- Lung Surgery
- Neck Surgery
- Ovary Removal
- Pacemaker
- Pancreatic Surgery
- Plastic Surgery
- Prostate Surgery
- Shoulder Surgery
- Sinus Surgery
- Skin Cancer Surgery
- Throat Surgery
- Thyroid Removal
- Tonsil Removal
- Total Hip Replacement
- Total Knee Replacement
- Tubal Ligation
- Vasectomy
- Weight Loss Surgery

Heart Valve Replacement mitral ◯ aortic ◯ tricuspid ◯ unknown valve ◯

Other Surgery (please specify): _____

FAMILY MEDICAL HISTORY

Please indicate which family member(s) have had these illnesses:

◯ **Family History UNKNOWN** ◯ **ADOPTED** ◯ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

	Father	Mother	Grandmother *Mother's side*	Grandfather *Mother's side*	Grandmother *Father's side*	Grandfather *Father's side*	Brother	Sister
Alcohol Abuse	◯	◯	◯	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯	◯	◯	◯
Bipolar	◯	◯	◯	◯	◯	◯	◯	◯
Bleeding Disease	◯	◯	◯	◯	◯	◯	◯	◯
Breast Cancer (Before 50)	◯	◯	◯	◯	◯	◯	◯	◯
Breast Cancer (After 50)	◯	◯	◯	◯	◯	◯	◯	◯
Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Colon Cancer (Before 50)	◯	◯	◯	◯	◯	◯	◯	◯
Colon Cancer (After 50)	◯	◯	◯	◯	◯	◯	◯	◯
COPD / Emphysema	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯	◯	◯	◯
End Stage Renal Disease (ESRD)	◯	◯	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯	◯	◯
High Cholesterol	◯	◯	◯	◯	◯	◯	◯	◯
Hypertension (High Blood Pressure)	◯	◯	◯	◯	◯	◯	◯	◯
Hypothyroidism (Low Thyroid)	◯	◯	◯	◯	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯	◯	◯	◯	◯
Ovarian Cancer		◯	◯		◯			◯
Prostate Cancer	◯			◯		◯	◯	
Seizures / Convulsions	◯	◯	◯	◯	◯	◯	◯	◯
Stroke / CVA of the Brain	◯	◯	◯	◯	◯	◯	◯	◯
Uterine Cancer		◯	◯		◯			◯

PREVENTATIVE HEALTH

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

	N/A	1 year 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+ years ago	RESULTS WERE: Normal	Abnormal	Don't Know
Mammogram	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Colonoscopy	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pap Smear	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Bone Density / Dexa Scan	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Prostate Cancer Screening	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Stool Hemoccult (blood in stool)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

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ALLERGIES

Please mark all allergies you have:

- ◯ I HAVE NO KNOWN ALLERGIES
- ◯ I HAVE NO KNOWN MEDICATION ALLERGIES

◯ Amoxicillin	◯ Erythromycin	◯ Phenergan	◯ Zithromax
◯ Cephalosporin	◯ Hydrocodone (with Acetaminophen)	◯ Sulfa	◯ Tape / Adhesive
◯ Codeine	◯ Morphine	◯ Tetracycline	◯ Latex
◯ Compazine	◯ Oxycodone	◯ Tylenol	◯ Eggs
◯ Demerol	◯ Penicillin	◯ Vancomycin	◯ Other (please specify):
◯ Dilaudid	◯ Percocet	◯ Vicodin	_____

MEDICATIONS

Please list all medications you are currently taking (include prescription, over-the-counter, vitamins and herbs):

ANTIDEPRESSANT			
	Effexor® (venlafaxine) ◯	Prozac® (fluoxetine) ◯	Wellbutrin® (bupropion) ◯
	Cymbalta® (duloxetine) ◯	Paxil® (paroxetine) ◯	Zoloft® (sertraline) ◯
BLOOD THINNERS			Plavix® (clopidogrel) ◯
	Aspirin ◯	Refludan® (lepirudin) ◯	Aggrastat® (tirofiban) ◯
	Coumadin® (warfarin) ◯	Ticlid® (ticlopidine) ◯	Integrilin® (eptifibatide) ◯
CARDIAC / HYPERTENSION		Dyazide® (hydrochlorothiazide) ◯	Inderal® (propranolol) ◯
	Capoten® (captopril) ◯	Nifedipine ◯	Tenormin® (atenolol) ◯
	Lisinopril ◯	Verapamil ◯	Lopressor® (metoprolol) ◯
	Cozaar® (losartan) ◯	Diltiazem ◯	Coreg® (carvedilol) ◯
	Diovan® (valsartan) ◯	Norvasc® (amlodipine) ◯	Toprol ◯
ANTI-INFLAMMATORY		Naproxen (Aleve®) ◯	**Prednisone:**
	Acetaminophen (Tylenol®) ◯	Ibuprofen ◯	currently taking ◯
	Celebrex® ◯	Meloxicam® (Mobic) ◯	taken in the past ◯
ANTI-ULCER			
	Prilosec® (omeprazole) ◯	Nexium® (esomeprazole) ◯	Tagamet® (cimetidine) ◯
	Prevacid® (lansoprazole) ◯	Protonix® (pantoprazole) ◯	Zantac® (ranitidine) ◯
CHOLESTEROL LOWERING			Niaspan® (niacin) ◯
	Lipitor® (atorvastatin) ◯	Crestor® (rosuvastatin) ◯	Gemfibrozil ◯
	Zocor® (simvastatin) ◯	Mevacor® (lovastatin) ◯	Zetia® ◯
PAIN MEDICATIONS	Fentanyl ◯	Neurontin® ◯	Tylenol #3® ◯
	Hydrocodone ◯	Oxycodone ◯	Vicodin® ◯
	Lyrica® ◯	OxyContin® ◯	Vistaril® ◯
	MS Contin ◯	Percocet® ◯	Zanaflex® ◯
OSTEOPOROSIS TREATMENT	Actonel® ◯	Fosamax® ◯	Boniva ◯
ALLERGY / ASTHMA		Singulair® (montelukast) ◯	Asthma-Steroid Inhaler ◯
	Allegra® (fexofenadine) ◯	Zyrtec® (cetirizine) ◯	(please specify):
	Claritin® (loratadine) ◯	Albuterol Inhaler ◯	_____
DIABETES	Micronase® ◯	Glucotrol® (glipizide) ◯	Insulin Injections ◯
	DiaBeta® ◯	Glucagon ◯	(please specify):
	Glynase® ◯	Avandia® (rosiglitazone) ◯	_____
	Glucophage® (metformin) ◯	Precose® (acarbose) ◯	_____
ANTIBIOTICS			Keflex® (cephalexin) ◯
	Amoxicillin ◯	Cipro® ◯	Levaquin® (levofloxacin) ◯
	Augmentin® (amoxicillin / clavulanate potassium) ◯	Cleocin® (clindamycin) ◯	Lamisil® (terbinafine hydrochloride) ◯
	Bactrim® (trimethoprim) ◯	Doxycycline ◯	Sporanox® (itraconazole) ◯
	Biaxin® (clarithromycin) ◯	Erythromycin ◯	Zithromax® (azithromycin) ◯
REPRODUCTIVE		Birth Control Pills ◯	Hormone Replacement ◯
		(please specify):	(please specify):
	Depo-Provera® Injections ◯	_____	_____
OTHER (please specify)			
	_____	_____	_____
	_____	_____	_____
HERBAL / SUPPLEMENTS (please specify)			
	_____	_____	_____
	_____	_____	_____