PATIENT HISTORY

TODAY'S DATE_____
PATIENT'S NAME:_____ **DOB:**_____ **AGE**:____
Referring Physician:_____
Primary Care Physician (family doctor):_____
Physicians you wish to receive reports: _____
REASON FOR TODAY'S VISIT:
_____

MEDICAL HISTORY:
Do you have or have you ever had cancer? If yes, what type?_____ **When?**_____

____Migraines
____Glaucoma
____TB
____Emphysema/COPD
____Asthma
____Sleep Apnea ___ CPAP
____Heart Attack
____Congestive Heart Failure
____Artificial Heart Valve
____Coronary Artery Disease
____Atrial Fibrillation
____Arrhythmia (Irregular heartbeat)
____Pacemaker
____Defibrillator
____Hypertension (High Blood Pressure)
____Hypercholesterolemia (High Cholesterol)
____Seizure Disorder
____Depression
____Anxiety
____Fibromyalgia
____Rheumatoid Disease
____Multiple Sclerosis

____Diabetes ____Diet ____Pills ____Insulin
____Hypothyroid (underactive)
____Hyperthyroid (overactive)
____Stroke
____TIA
____DVT
____Aneurysm Type:_____
____Bleeding Disorder
____History of Blood Transfusion
____Diverticulitis
____Irritable Bowel Disease (IBS)
____Crohn's Disease
____Colitis Type:_____
____Hiatal Hernia
____Hepatitis
____GERD/Reflux Disease
____Peptic Ulcer Disease
____Kidney Disease ___w/dialysis ___w/o dialysis
____Anemia
____HIV/AIDS
____History of Sexually Transmitted Disease/HPV
____MRSA Date_____

SURGICAL HISTORY:

Circle:	**Date:**	**Circle:**	**Date:**
Yes/No Appendectomy	_____	Yes/No Heart Valve Replacement	_____
Yes/No Breast Lumpectomy__R__L	_____	Yes/No Hernia Repair	_____
Yes/No Mastectomy __R__L	_____	Yes/No Hysterectomy	_____
Yes/No Cholecystectomy (Gallbladder)	_____	Yes/No Joint Replacement	_____
Yes/No Colonoscopy	_____	Which Body Part?_____	R__L___
Yes/No Colon/Rectal Surgery	_____	Yes/No Prostate	_____
Yes/No C-Section	_____	Yes/No Thyroid	_____
Yes/No Gastric Bypass/Sleeve	_____	Yes/No Tonsils/Adenoids	_____
Yes/No Heart Bypass (CABG)	_____	Yes/No Tubal Ligation	_____
Yes/No Heart Stents	_____	Yes/No Vasectomy	_____

ANY ADDITIONAL SURGERIES: _____
_____

ANESTHESIA HISTORY: _____ None_____Nausea/Vomiting _____Difficulty Awakening
_____Family History Anesthetic Complication_____ Malignant Hyperthermia_____Difficult Airway

FAMILY HISTORY: List any family members who have or have had any of the following:
_____ Colon Polyps _____ Ovarian Cancer
_____ Breast Cancer _____ Crohn's Disease
_____ Colon Cancer _____ Uterine Cancer
Other Forms of Cancer: _____

SOCIAL HISTORY:

Tobacco ____Smoke_____packs/day for_____years ____Quit _____years
Alcohol ___Social ___Daily ____Quit _____years **Drugs** ___Marijuana _____Cocaine ____IV ____ Other

OCCUPATION: _____

REVIEW OF SYMPTOMS:

Ear/Nose/Throat: ____ None
____Hearing loss/hearing aid
____Difficulty swallowing/opening mouth
____Seasonal allergies
____Dentures/Caps/Crowns/Bridges/Braces
Pulmonary: ____ None
____Shortness of breath
____Chronic/frequent cough
____Wheezing
Cardiovascular: ____ None
____Chest pain/angina
____Palpitations
____Heart murmur
____Shortness of breath with walking or lying flat
____Low blood pressure
Gastrointestinal: ____ None
____Hemorrhoids
____Change in bowel habits
____Nausea or vomiting
____Constipation
____Diarrhea
____Rectal bleeding or blood in stool
____Abdominal pain – How long? _____
____Indigestion/heartburn
____Black/tarry stools
____Rectal pain
____Anal itching
Bowel Accidents:___None
____Leakage of stool
____Fecal Incontinence

Constitutional: ____ None
____Weight loss
____Weight gain
____Fatigue
____Fevers
Genitourinary: ____ None
____Frequent urination
____Frequent UTI's
____Urinary incontinence
____Recent PSA _____
____Enlarged prostate
Neurologic: ____ None
____Fainting
____Seizures – Date of last seizure _____
____Paralysis
Skin: ____ None
____Rashes/lesions
____Cancer
Musculoskeletal: ____ None
____Joint pain
____Muscle disorder
____Back pain
Immune/Other: ____ None
____Immunosuppression
____Body piercings
OB/GYN: ____ None
____Pregnant # of Pregnancies _____
# of Births_____Vaginal_____C-Section
Last Menstrual Period _____

MEDICATIONS: List all medications including blood thinners (Plavix, Coumadin, aspirin, etc.). Please include Dose, Frequency, and Reason for Taking.

Prescription Medication: Dose: Frequency: Reason for Taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Over-the-Counter Medications/ Vitamins/Herbal Supplements: Dose: Frequency: Reason for Taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES: Please list allergies below, with reaction. If no allergies, please check None _____NONE

MEDICATION ALLERGIES:

Allergy	**Reaction**	**Allergy**	**Reaction**
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

SOY ALLERGY: ____Yes ____ No Type of reaction: _____

EGG ALLERGY: ____Yes ____No Type of reaction: _____

GLUTEN: ____Yes____No Type of reaction: _____

CAT SCAN DYE: ____Yes ____No Type of reaction: _____

LATEX ALLERGY: ___Yes ___No Type of reaction: _____

Reviewed with patient _____MD/DO/PA