F02-9/14

Patient History Form

Last Name	First Name, Middle Initial	Date of Birth
Primary Care Physician	Other doctors involved in your care:	

PLEASE DO NOT WRITE IN THIS BOX BELOW. FOR OFFICE STAFF ONLY

Nurses / Doctors notes:
Tests or labs ordered today:

WHAT IS THE REASON FOR YOUR VISIT WITH US TODAY :

Chief Complaint:

HAVE YOU HAD OR BEEN DIAGNOSED WITH ANY OF THESE ISSUES IN THE PAST.

System	*Yes*	*No*	*YR*	*System*	*Yes*	*No*	*YR*	*System*	*Yes*	*No*	*YR*
Cardiac				**Neurologic**				**Ear, Nose, Throat**			
High blood Pressure				Seizures				Loose Teeth			
Low blood pressure				Weakness				Nosebleeds			
Irregular Heartbeat				Migraines				Deafness			
Chest Pain				Previous stroke				**PSYCHOSOCIAL**			
High Cholesterol				**Musculoskeletal**				Alcoholism			
Vascular Disease				Muscle disease				Substance abuse			
RESPIRATORY				Arthritis				Depression			
Asthma				Neck Pain				Anxiety disorders			
Pneumonia				Back pain							
Bronchitis				Blood disorder							
Chronic cough				**What type of disorder please list below:**				**Please list below Any symptoms or Diseases not listed:**			
Hoarseness											
Tracheostomy											
COPD				Rash							
Tuberculosis				**MRSA**							
GENITOURINARY				Bruises							
Kidney Disease				**OPTHALMIC**							
Chronic Renal Failure				Blindness							
Are you currently on Dialysis				Cataracts				***Have you been diagnosed with Cancer? Please list:***			
Urine Infection				Glaucoma							
Endocrine/Metabolic				**BREAST**							
Diabetes TYPE I / TYPE II				Lumps							
Thyroid Disorders				Cancer							

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING GASTROINTESTINAL AND HEPATIC SYMPTOMS RECENTLY?

System	*TODAY*	*IN THE PAST TWO MONTHS*	*PLEASE INDICATE IF THIS ISSUE HAS BEEN RESOLVED BY WRITING "RESOLVED" or you may explain.*
Gastrointestinal			
Diarrhea			
Constipation			
Rectal Bleeding			
Change in bowel habits			
Weight Loss			
Dark Stools			
Irritable Bowel			
Crohn's Disease			
Ulcerative Colitis			
Trouble Swallowing			
Nausea/Vomiting			
Heartburn			
Abdominal Pain			
HEPATIC			
End stage liver disease			
Cirrhosis			
Hepatitis			
Pancreatitis ACUTE/CHONIC			

PAST GASTROINTESTINAL PROCEDURES:	**YES**	**NO**	**APPROXIMATE DATE OF PROCEDURE**	**WERE POLYPS FOUND?**	**ANY ABNORMAL FINDINGS PLEASE EXPLAIN:**
HAVE YOU EVER HAD A COLONOSCOPY IN THE PAST?					
HAVE YOU EVER HAD AN UPPER ENDOCOPY (EGD?					
Have you:	**YES**	**NO**	**APPROXIMATE DATE**		
Ever had a blood transfusion?					
Donated blood?					
Do you have tattoos (yr of oldest)					

Have you ever had any surgery or been hospitalized?____Yes____No Have you had any problems with anesthesia? Yes No If yes, please list below	Surgeries	Dates	Hospitalizations other than surgery	Dates

Social History:	Alcohol: How many drinks per day?_____Per week?_____Per month?_____ Do you currently use street drugs____Yes_____No if yes How often? _____ Have you ever used street drugs_____Yes____No When did you quit?_____
Tobacco use: Please check one: Non Smoker: _____ Current smoker_____ Former Smoker_____	Tobacco: How many packs per day?_____for how many years?_____ At what age did you begin Smoking?_____Year quit _____
Please list any allergies, including environmental, medication, food, and reaction to previous blood transfusion.	

Family History **Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions**

Condition	*Relation*	*Living/Deceased?*	*Condition*	*Relation*	*Living/Deceased?*	*Condition*	*Relation*	*Living/Deceased?*
Colon/ Rectal Cancer No___Yes____			Kidney problems No___Yes____			Heart Disease No___Yes___		
Stomach Cancer No___Yes____			Ulcerative colitis No___Yes___			Crohns Disease No___Yes___		
Breast Cancer No___Yes____			Ovarian Cancer No___Yes____			Bleeding Problems No___Yes___		

Please indicate in this section any issues we have not addressed on this form:

_____

_____

_____

_____

_____

********Patients: please do not sign until the Medical Assistant has gone over this information with you********

I_____agree that the information I have provided on this patient History
Patient name
Form is accurate to the best of my knowledge. The Medical Assistant has reviewed the information with me in the room and I agree that this information will become part of my permanent medical record.

_____ _____
Printed Patient Name Today's date

_____
Patient Signature

FOR OFFICE USE ONLY, PATIENTS PLEASE DO NOT WRITE BELOW THIS LINE

The above information has been reviewed and discussed with the patient:	Date information reviewed	Staff name/Title	Signature
PLEASE CIRCLE ONE **YES / NO**			
Patient refused**: YES / NO**	Reason if any:		