PATIENT HISTORY FORM

MRN/CSN #

Name_____ **Date of Birth**_____

Please circle Yes for each problem that applies to you:

Yes Allergies
Yes Anemia
Yes Anxiety
Yes Arthritis
Yes Blood Transfusion
Yes Cancer-if Yes, please state type _____
Yes Cataracts
Yes Coronary Artery Disease
Yes Heart Failure
Yes Clotting Disorder
Yes COPD
Yes Cholesterol Problems
Yes High Blood Pressure
Yes Depression
Yes Diabetes Mellitus
Yes Emphysema
Yes GERD
Yes Glaucoma
Yes Heart Attack
Yes Heart Murmur
Yes HIV/AIDS
Yes Kidney Disease
Yes Meningitis
Yes Nerve/Muscle Disease
Yes Osteoporosis
Yes Seizures
Yes Sickle Cell Anemia
Yes Stroke
Yes Substance Abuse
Yes Stomach Ulcers
Yes Thyroid Disease
Yes Tuberculosis
Yes Heavy snoring/sleep apnea

FEMALES ONLY
Age of last period_____
Number of Pregnancies_____
Age at Menopause_____
Number of Children_____
History Abnormal Pap Smear
☐ Yes ☐ No

Please mark the box for each surgery that applies to you:

☐ Appendix Removal
☐ Brain Surgery
☐ Cardiac Bypass Surgery
☐ Cardiac Stent Placement
☐ Colon Surgery
☐ Cosmetic Surgery
☐ Ear Surgery-Ear Tubes
☐ Eye Surgery
☐ Other _____
☐ Fracture Surgery
☐ Gall Bladder Surgery
☐ Gastric Bypass Surgery
☐ Hernia Repair
☐ Hysterectomy
  ☐ Total
  ☐ Partial
☐ Joint Replacement
☐ Prostate Surgery
☐ Small Intestine Surgery
☐ Spine Surgery
☐ Tonsillectomy/Adenoidectomy
☐ Thyroidectomy
☐ Valve Replacement
☐ Vascular Surgery
☐ Vasectomy

Please indicate your occupation or job _____

Please indicate your marital status _____

Please circle and answer each question as they apply to you:

Yes No **Alcohol Use** **Indicate how many drinks per week:**
_____ Cans of Beer
_____ Shots of Liquor
_____ Drinks containing 0.5 oz of alcohol
_____ Glasses of Wine

Yes No **Sexually Active,** **Partners** ☐ Female ☐ Male

Yes No **Drug Use** **Comment**_____

Yes No **Tobacco Use** **Pack per Day** _____ **Quit Date**_____
Years as a Smoker _____

Yes No **Tobacco, Smokeless** **Comment**_____
Amount Each Day_____ **Quit Date**_____

Yes No **Caffeine Intake** **Comment**_____

PATIENT HISTORY FORM

MRN/CSN #

Name_____ **Date of Birth**_____

Please indicate your family history in the boxes below:

Relationship	Mother	Father	Sister	Brother	Daughter	Son	Mom's Father	Mom's Mother	Dad's Father	Dad's Mother
Problem										
Alcohol Abuse										
Aneurysm										
Arthritis										
Asthma										
Birth Defects										
Breast Cancer										
Colon Cancer										
Other Cancers										
COPD										
Depression										
Diabetes										
Drug Abuse										
Early Death										
Gastric Cancer										
Glaucoma										
Heart Disease										
Hyperlipidemia										
Hypertension										
Kidney Disease										
Learning Disabilities										
Macular Problems										
Mental Illness										
Mental Retardation										
Miscarriages										
Stroke										
Thyroid Disease										
Other										

Please list your Current Medications below: Include Strength and number of times taken daily.

Please indicate your preferred Pharmacy: Include location.

Please describe any Allergies: Include a description of your reaction.

Please indicate any other Medical Problems not addressed in this form: