



Account # _____

Patient Information for Medical Records

Please either mail, fax or drop off this health history at least 4 days prior to your scheduled appointment date or plan to arrive one hour prior to your scheduled appointment.

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle initial	Date of Birth Age:	Social Security Number
Street Address	City	Zip	Home Phone	Cell Phone
Drivers License	Marital Status	Sex M F	Race (optional)	Religion (optional)
Occupation	Employer			Business Phone
Person to notify in case of emergency:		Telephone	Address:	
Primary Care Physician		Address		Telephone
Referring Physician		Address		Telephone
Pharmacy		Address		Telephone
FOR YOUR CONVENIENCE OUR DISPENSARY MAY BE ABLE TO FILL YOUR PRESCRIPTIONS				

Briefly describe your present medical symptoms and diagnosis:

FAMILY HISTORY	IF LIVING			IF DECEASED	
	Sex	Age	Health	Age at Death	Cause
Father					
Mother					
Brothers/Sisters (circle Sex)	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife	M F				
Sons/Daughters (circle Sex)	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
	M F				

Patient Name: _____
Patient Number: _____

MEDICATIONS: *Please list the medications you are taking. Use additional sheet(s) if necessary.*

MEDICATION:	STRENGTH:	FREQUENCY:

ALLERGIES: _____

OPERATIONS: Write in the type and the year _____

Have you ever had a **transfusion**? If so when?: _____

Write in the names of any **diseases** you have had which required hospitalization: _____

Serious **illnesses** which you have had: (not requiring hospitalization) _____

Serious **injuries or accidents:** _____

Has your weight changed in the past year? If so, by how much? _____ How tall are you: _____

Do you know of any blood relative who has or had:

(Circle)	(Relationship)	(Circle)	(Relationship)
Stroke	_____	Epilepsy	_____
Cancer	_____	Suicide	_____
High Blood Pressure	_____	Migraine	_____
Tuberculosis	_____	Asthma	_____
Diabetes	_____	Hay Fever	_____
Leukemia	_____	Bleeding tendency	_____
Rheumatic heart	_____	Insanity	_____
Heart Attack	_____	Arthritis	_____
Stomach ulcers	_____	Colitis	_____
Kidney Disease	_____	Nervous breakdown	_____
Goiter	_____	Congenital heart	_____

Personal Habits: (circle each question below either yes or no)

Do you regularly smoke Yes No Cigarettes Pipe Cigars For how long? _____
Do you drink caffinated beverages? Yes No How many per day? _____
Do you have difficulty falling asleep? Yes No Do you awaken without apparent cause? Yes No
Do you regularly drink alcohol? Yes No How many ounces per day? _____
Beer - bottles per day? _____

Patient Name: _____
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Do you frequently have severe **headaches**? Yes No (if yes, answer the following):
 Do they cause visual trouble? Yes No Do they occur on one side of the head? Yes No
 Do they feel like a tight hat band? Yes No Do they awaken you at night from sleep? Yes No
 Do they hurt most in the back of the head/neck? Yes No Does aspirin relieve them? Yes No

Have you ever fainted? Yes No Have you ever had a convulsion? Yes No
 Spells of dizziness? Yes No Double vision? Yes No
 Spells of weakness of an arm or leg? Yes No Pains in ear? Yes No
 Ringing in ears? Yes No Nosebleeds? Yes No

Have you ever been treated for depression? Yes No
 Have you ever been treated for anxiety? Yes No
 Have you ever seen a psychologist / psychiatrist? Yes No
 Comments:

Do you frequently experience any of the following:

Bleeding gums? Yes No Sore tongue? Yes No
 Trouble swallowing? Yes No Nausea and vomiting? Yes No
 Hoarseness? Yes No

Have you ever had shortness of breath?

Doing your usual work? Yes No Which causes you to cough? Yes No
 Climbing a flight of stairs? Yes No Accompanied by sneezing? Yes No
 Which awakens you at night? Yes No Have you ever coughed blood? Yes No
 Do you have a chronic cough? Yes No Do you cough up much sputum? Yes No

Have you ever had chest pain or tightness in the chest?

When exerting yourself? Yes No Which radiates down the arm? Yes No
 When walking against a wind? Yes No Which disappears if you rest? Yes No
 When walking up a hill? Yes No Which occurs only at rest? Yes No
 After a heavy meal? Yes No When walking fast? Yes No
 When upset or excited? Yes No When walking in cold weather? Yes No

If you have chest pain or tightness please explain:

Have you ever had pain in the stomach which:

Occurs 1-2 hours after a meal? Yes No Occurs only at rest? Yes No
 Is brought on by eating fried or gassy foods? Yes No Awakens you at night? Yes No
 Is relieved by antacid medications? Yes No Is relieved with milk or eating? Yes No
 Occurs while eating or immediately after? Yes No Do you have a loss of appetite? Yes No
 Is relieved by a bowel movement? Yes No

If you have had a change in bowel habit recently answer the following:

	Yes	No	When or since when?
Crampy pain in the abdomen?	Yes	No	_____
Alternating diarrhea and constipation?	Yes	No	_____
Pain during or after bowel movement?	Yes	No	_____
Mucous in the stool?	Yes	No	_____
Blood in the stool?	Yes	No	_____
Ribbon-like stools?	Yes	No	_____
Require use of strong laxatives or enemas?	Yes	No	_____

Have you had:

	Yes	No	When or since when?
Burning when urinating?	Yes	No	_____
Loss of control of bladder?	Yes	No	_____
Blood in the urine?	Yes	No	_____
Dark colored urine?	Yes	No	_____
Trouble starting to urinate?	Yes	No	_____
Trouble holding the urine?	Yes	No	_____
Getting up frequently at night?	Yes	No	_____
Passed a kidney stone?	Yes	No	_____

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Have you recently had:			When or since when?
Pains in calves or legs when walking?	Yes	No	_____
Cramps in legs at night?	Yes	No	_____
Pain in the big toe?	Yes	No	_____
Varicose veins?	Yes	No	_____
Phlebitis or inflamed leg veins?	Yes	No	_____
Swelling in the ankles?	Yes	No	_____

To be answered by **WOMEN** only:

Do you have regular monthly menstrual periods?	Yes	No	Age at onset of menarche?	_____
Have you ever had bleeding between periods?	Yes	No	When?	_____
Do you have heavy bleeding with your periods?	Yes	No	When?	_____
Do you feel bloated/ irritable before your period?	Yes	No	When?	_____
Do you take/have you taken the birth control pill?	Yes	No	When?	_____
How many children born alive?	_____		How many stillbirths?	_____
How many premature births?	_____		How many miscarriages?	_____
How many cesarean operations?	_____		Age at time of 1st child?	_____
Any complications of pregnancy?	_____			

Date of last menstrual period?	_____		Are you in menopause?	Yes	No
Do you regularly have pap smears?	_____	Yes	No	Age at time of menopause?	_____
Date of last test?	_____		Was menopause spontaneous?	Yes	No
Have you ever had discharge from the nipple?	Yes	No	Menopause due to hysterectomy?	Yes	No
Have you taken hormones?	Yes	No			

To be answered by **MEN** only: Have you ever had:

Loss of sexual activity?	Yes	No	For how long? _____
Treatment for genitals?	Yes	No	
Discharge from penis?	Yes	No	
Hernia (rupture)?	Yes	No	
Prostate trouble?	Yes	No	

Do you wish any further information about Advance Directives? Yes No