COMPREHENSIVE PATIENT HISTORY
PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOU APPOINTMENT

Your name:_____ Date of Birth:_____ Today's date:_____

Who referred you to us? _____ Phone number: _____
Who is your primary care physician? _____Phone number: _____

What type of complaint or disease is the reason for requesting this visit? _____
_____

TELL US ABOUT YOURSELF:
Home situation (check, or add in writing):
Single _____ Married _____ Divorced_____ Widowed_____ Domestic Partnership_____
Children? _____ Their Medical History_____

Employment:
Status: full-time_____ part-time_____ retired_____ disabled _____ homemaker_____
Occupation: _____

Personal History:
Do you smoke? No_____ Yes_____ If yes, how many packs per day?_____
If you have quit, how long ago?_____
Do you use alcohol? No_____ Yes_____ If yes, how often do you drink?_____
If you have quit, how long ago?_____
Have you ever used recreational drugs?_____

MEDICAL HISTORY:
Please list other diseases from which you ***currently*** suffer:
_____
_____
_____
_____
Please list other medical conditions from which you have suffered in the past_____
_____
_____
_____
Please list any surgeries, reason for the surgery and the date of surgery:
_____
_____
_____
_____

FAMILY HISTORY:
Place an "X" in the appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member						
	father	mother	brother	sister	son	daughter	other
Colon/rectal cancer							
Other cancer							
Heart disease							
Diabetes							
High blood pressure							
Liver disease							
High cholesterol							
Alcohol/drug abuse							
Depression/psychiatric illness							
Genetic (inherited) disorder							
Other							

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of drug reaction_____

MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION/HERBAL PREPERATIONS: (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives etc.)

Over-the-counter medications	Dose	How often taken

SYMPTOM REVIEW

Gastrointestinal
- poor appetite
- abdominal pain
- indigestion
- trouble swallowing
- diarrhea
- constipation
- change in bowel habits
- nausea or vomiting
- rectal bleeding or blood in stools
- history of liver disease or abnormal liver tests

Cardiovascular
- chest pain
- history of angina/heart attack
- history of high blood pressure
- history of irregular beat
- history of poor circulation

Pulmonary/lungs
- shortness of breath
- persistent cough
- coughing up blood
- asthma or wheezing

Muscle/joint/bone
- swelling of ankles or legs

Pain weakness or numbness in
- arms or hands
- back or hips
- legs or feet
- neck or shoulders

Neurologic
- history of stroke
- black outs or loss of consciousness

General
- weight gain/loss
- poor sleep
- fever
- headache
- depression

Eyes, ears, nose & throat
- blurred vision
- other vision changes
- glaucoma/cataracts
- loss of hearing
- ringing in ears
- sinus problems
- hoarseness

Genitourinary
- frequent painful urination
- blood in urine

Skin
- itching
- easy bruising
- change in moles

Endocrine
- history of diabetes
- history of thyroid disease
- change in tolerance to hot/cold
- excessive thirst

Women only
- abnormal pap test
- bleeding between periods

Men Only
- PSA

Anything else?
- Are you experiencing an unusually stressful situation?
- Are there any specific personal issues you would like to bring up at the time of your visit?