

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

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?

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