Patient History Form

PATIENT'S NAME: _____ DATE:_____

REASON FOR TODAY'S VISIT: _____
(What part of your body are you here to see us for and why. BE SPECIFIC)

_____

_____

_____

DATE SYMPTOMS FIRST BEGAN: _____

TREATMENT RECEIVED (Include Physicians Name):_____

_____

X-RAYS TAKEN (check one): YES ☐ NO ☐ WHERE: _____

DO YOU SMOKE? _____ DO YOU DRINK ALCOHOL? _____ IF SO, HOW MANY IN A DAY? _____

HAVE YOU HAD THE FLU VACCINE? YES ☐ NO ☐ IF YES, WHEN WAS YOUR LAST VACCINE? _____

HAVE YOU HAD THE PNEUMONIA VACCINE? YES ☐ NO ☐ IF YES, WHEN WAS YOUR LAST VACCINE? _____

DO YOU HAVE AN ADVANCE DIRECTIVE (ADVANCED CARE PLAN)? YES ☐ NO ☐
IF YES, DATE: _____ IF NO, ARE YOU INTERESTED IN INFORMATION? YES ☐ NO ☐
IF YES, _____PROVIDED PATIENT WITH INFORMATION ON ADVANCE DIRECTIVES ON _____

HEIGHT: _____ WEIGHT: _____ B.P.:_____

PAST SURGICAL HISTORY: (LIST PROCEDURE AND DATE): _____

_____

PAST HOSPITALIZATION: (LIST REASON AND DATE): _____

_____

CHRONIC MEDICAL PROBLEMS: _____

_____

ARE YOU TAKING ANY MEDICATION? YES ☐ NO ☐ IF YES, PLEASE SEE PATIENT MEDICATION FORM ATTACHED

Family History of

Y	N	Family Member
☐	☐ Alzheimer's Dz	_____
☐	☐ CAD	_____
☐	☐ Diabetes	_____
☐	☐ High Cholestrol	_____
☐	☐ Thyroid Dz	_____

Family History of

Y	N	Family Member
☐	☐ Cancer	_____ORIGIN_____
☐	☐ Depression	_____
☐	☐ Glaucoma	_____
☐	☐ HTN	_____
☐	☐ Other	_____

ALLERGIC TO ANY KNOWN MEDICATIONS: _____

_____