# Patient History

It is the patient's responsibility to provide complete, accurate information when completing this form. Signature is required.

Patient Name (First, Last, MI) _____

Date of Birth (mm/dd/yyyy) _____ Are you here due to a work related injury? Y ___ N ____
Family Doctor Name: _____ Date of Last Visit (mm/dd/yyyy) ___/___/____

Please describe the reason for your visit today: _____
Employed? Yes / No If yes Do you stand on your feet all day? Yes / No What type of job do you do? _____
Do you have an Advance Directive in place? re: Power of Attorney or a Living Will Y N
If *NO* do you want a brochure regarding this information? Y N

**CURRENT MEDICATIONS (** List all medications you are currently taking )

_____

_____

**ALLERGIES (** List all allergies, if no allergies write NONE )_____

**SOCIAL HISTORY**
Smoker? Yes___ How Much? _____ No___ Quit___ When? _____ Drink Alcohol? Yes ___
How Much? _____ No ___ Drug Abuse? Yes ___ No ___
Marital Status S / M / W / D

**PAST and FAMILY HISTORY**
Please indicate if you or a family member have had any of the following (indicate **M**other, **F**ather, **S**ister, **B**rother).

| **Self Family (list M,F,S,B)** | **Self Family (list M,F,S,B)** | **Self Family (list M,F,S,B)** |
|---|---|---|
| ___ _____ Heart Attack/Angina | ___ _____ Lupus | ___ _____ Gout |
| ___ _____ Heart Disease/Murmur/Failure | ___ _____ Cancer _____ | ___ _____ Asthma/Hay Fever |
| ___ _____ High Blood Pressure | ___ _____ Emphysema / Home Oxygen | ___ _____ HIV |
| ___ _____ High Cholesterol | ___ _____ Pneumonia / COPD | ___ _____Tuberculosis |
| ___ _____ Glaucoma/Eye disease | ___ _____ Phlebitis (blood clot) | ___ _____ Diabetes – ID / NID |
| ___ _____ Kidney Disease/ stones | ___ _____ Prostate Problems | ___ _____ Neuropathy _____ |
| ___ _____ Gall Stones | ___ _____Stroke | ___ _____ Liver Disease |
| ___ _____ Bleeding Tendencies | ___ _____ Arthritis (unknown) | ___ _____ Depression |
| ___ _____ Hepatitis if yes, type ____ | ___ _____ Rheumatoid / Osteoarthritis | ___ _____ Fibromyalgia |
| ___ _____ Seizure/Convulsions | ___ _____ Osteoporosis | ___ _____ PVD |

**SURGICAL HISTORY** Check if you have had any of the following surgeries.

| | | | |
|---|---|---|---|
| ___ Hip Replacement | ___ Neck | ___Tonsils/Adenoids | ___ Foot RT / LT |
| ___ Knee Replacement | ___ Back | ___ Breast | ___ Ankle RT / LT |
| ___ Arthroscopy _____ | ___ Appendectomy | ___ Hernia | ___ Heart _____ |
| ___ Hysterectomy/D&C/Tubal | ___ Eye/Cataract | ___ Gallbladder | ___Other _____ |
| ___ Hand / Carpal Tunnel | ___Shoulder / Rotator cuff | ___ Colonoscopy | ___Other _____ |

**REVIEW of SYSTEMS** Circle **Y**es or **N**o if you have a problem with any of the following systems:

| | | | | | |
|---|---|---|---|---|---|
| Constitutional (General Health) | Y N | Skin | Y N | Endocrine | Y N |
| Ears/Nose/Throat | Y N | Psychiatric | Y N | Neurological | Y N |
| Cardiovascular | Y N | Gastrointestinal | Y N | Respiratory | Y N |
| Blood Disorder | Y N | Eyes | Y N | Urinary/Genital | Y N |
| Allergy/Immunologic | Y N | Musculoskeletal | Y N | | |

***DO NOT COMPLETE THIS SECTION (OFFICE USE)*** Chief Complaint: ***NEW PATIENT or ANNUAL UPDATE*** ***Alert added*** ____

_____

_____

Other Doctor Seen For this Problem: _____ Date last seen for problem: ____/___/____
Accident YES____ NO_____ If yes, DOI/Onset Date ____/____/_____ Accident Location_____
Height: _____ Weight: _____ Blood Pressure _____/_____ Pulse _____ Respiration: _____

**Patient Signature:**_____ **Date:** _____/_____/_____

**Physician Signature:**_____ **Date:**_____/_____/_____ **MRN** _____