Patient History

Last Name	First Name	MI	Date of Birth
Marital Status Single Divorced Married Widow/Widower	Who Lives With You?		
Employer	Occupation	What kind of work?	
Primary Care Physician	Other doctors involved with your care:		

REVIEW OF SYSTEMS

Have you or the patient ever been diagnosed with any of the following. If yes, please check any that apply and explain in the space provided.
Is your family physician aware of any symptoms/illnesses that you have checked below? ☐ Yes ☐ No

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Gastrointestinal			Cardiac			Neurologic			Ear, Nose, & Throat		
Diarrhea			High blood pressure			Seizures			Loose Teeth		
Constipation			Low blood pressure			Weakness			Nosebleeds		
Rectal Bleeding			Irregular heartbeat			Migraines			Deafness		
Change in BM's			Chest pain			Previous stroke			Psychosocial		
Weight loss			Respiratory			Musculoskeletal			Alcoholism		
Polyps			Asthma			Muscle Disease			Substance Abuse		
Irritable Bowel			Pneumonia			Arthritis			Depression		
Crohn's Disease			Bronchitis			Neck pain			Anxiety Disorders		
Ulcerative Colitis			Chronic Cough			Back pain			Breast		
Trouble Swallowing			Hoarseness			Blood Disorders			Lumps		
Nausea/Vomiting			Tracheostomy			Skin			Cancer		
Heartburn			Genitourinary			Rash			Please list below:		
Abdominal Pain			Kidney Disease			Bruises			Any symptoms/diseases not listed above?		
Hepatic			Frequent urine infection			Ophthalmic					
Liver Disease			Endocrine/Metabolic			Cataracts					
Hepatitis			Diabetes			Glaucoma					
Pancreatitis			Thyroid Disorders			Blindness					

PAST HISTORY

Please explain any YES answers in detailed description in the box provided.

Have you ever had any surgery or been Hospitalized? ☐ No ☐ Yes Have you had any problems with anesthesia? No____ Yes____ If yes, please list below:	Surgeries	Dates	Hospitalizations other than surgery	Dates

Tobacco use:	Alcohol use:	Alcohol: How many drinks ☐ per day____ ☐ per week____ ☐ per month____
Current YES___ NO___ Prior YES___ NO___	Current YES___ NO___ Prior YES___ NO___	Tobacco: How many packs per day ☐____ For how many years?____

Are you currently or have you ever used recreational/illicit drugs?	☐ No ☐ Yes	If yes, what kind? For how long?
Are you currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	☐ No ☐ Yes	
Do you have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)?	☐ No ☐ Yes	

Medication	Dose	Times	Medication	Dose	Times

FAMILY HISTORY: Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Colon/Rectal Cancer No___ Yes___		Kidney Problems No___ Yes___		Heart Disease No___ Yes___	
Stomach Cancer No___ Yes___		Ulcerative Colitis No___ Yes___		Crohn's Disease No___ Yes___	
Breast Cancer No___ Yes___		Ovarian Cancer No___ Yes___		Bleeding Problems No___ Yes___	

Person Completing This Form/Relationship to Patient _____ Date _____

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