PATIENT HISTORY FORM

MR#: _____

Date of Birth _____ Last Name: _____

First Name, Middle Initial: _____ Primary Care Physician: _____

FOR OFFICE STAFF ONLY. PLEASE DO NOT WRITE IN BOX BELOW.

Nuse/Doctor notes:

_____

_____

Tests or labs ordered today:

_____

Have you been diagnosed with any of these issues? Currently or in the past.

CARDIAC	Yes	No	Year	NEUROLOGIC	Yes	No	Year
High blood pressure				Seizures			
Low blood pressure				Weakness			
Irregular heartbeat				Migraines			
Chest pain				Previous stroke			
High cholesterol				MUSCULOSKELETAL			
Vascular Disease				Muscle disease			
Pacemaker				Arthritis			
RESPIRATORY				Neck pain			
Asthma				Back pain			
Pneumonia				Blood disorder			
Bronchitis				Rash			
Chronic cough				MRSA			
Hoarseness				Bruises			
Tracheostomy				OPHTHALMIC			
COPD				Blindness			
Tuberculosis				Cataracts			
GENITOURINARY				Glaucoma			
Kidney disease				PSYCHOSOCIAL			
Chronic renal failure				Alcoholism			
Dialysis				Substance abuse			
Urine infection (UTI)				Depression			
ENDOCRINE/METABOLIC				Anxiety disorders			
Diabetes TYPE I or II				CANCER? Please list below:			
Thyroid disorder							

Have you experienced any of the following gastrointestinal and hepatic symptoms recently?

Symptom/Illness	**Today**	**Frequency in the past 2 months**	**Indicate if this issue is resolved or if not, please elaborate**
Diarrhea			
Constipation			
Rectal bleeding			
Change in bowel habits			
Weight loss			
Dark stools			
Irritable bowel			
Crohn's disease			
Ulcerative colitis			
Ulcerative colitis			
Trouble swallowing			
Nausea/Vomiting			
Heartburn			
Abdominal pain			
End-stage liver disease			
Cirrhosis			
Hepatitis			
Pancreatitis ACUTE/CHRONIC			

Past gastrointestinal procedures:	Yes	No	Approximate date	Were polyps found?	Any abnormal findings? Please explain
Colonoscopy?					
Upper endoscopy? (EGD)					
Have you:					
Had a blood transfusion?					
Donated blood?					
Tattoos? (year of oldest tattoo?)					
Have you ever had surgery or been hospitalized?					
Problems with anesthesia?					

Social history	Alcohol: How many drinks per day?____ Per week? ____ Per month? ____ Do you currently use street drugs? Yes ____ No ____ If yes, how often? _____ Have you ever used street drugs? Yes ____ No ____ Last use? _____
Tobacco use Please check one: • Non-Smoker ___ • Current smoker ___ • Former Smoker ___	Tobacco: How many packs per day? ____ For how many years? ____ At what age did you begin Smoking? ____ Year quit? ____

Please list any allergies, including environmental, medication, food, and any reactions to previous blood transfusion:

_____

_____

Family history:

Condition	Relation	Living/deceased?	Condition	Relation	Living/ deceased?
Colon/Rectal Cancer No ___ Yes ___			Kidney problems No ___ Yes ___		
Stomach cancer No ___ Yes ___			Ulcerative colitis No ___ Yes ___		
Breast cancer No ___ Yes ___			Heart disease No ___ Yes ___		
Crohn's disease No ___ Yes ___			Bleeding problems No ___ Yes ___		
Ovarian cancer No ___ Yes ___					

Please indicate in this section any issues we have not addressed on this form:

_____

_____

Patients: please do not sign until the Medical Assistant has gone over this information with you

I _____agree that the information I have provided on this patient history form is accurate to the best of my knowledge. The Medical Assistant has reviewed the information with me in the room, and I agree that this information will become part of my permanent medical record.

_____ _____

Patient Signature Date

FOR OFFICE USE ONLY. PATIENTS, PLEASE DO NOT WRITE BELOW THIS LINE.

The above information has been reviewed/discussed wtih the patient. No ___ Yes ___

Date reviewed _____ Staff name/Title_____Signature_____

Patient refused? No ___ Yes ___ If refused, reason: _____