Patient History Sheet

(All Information is strictly Confidential)

Name: **Age:** **Date:** **Date of last physical exam:**

Reason for visit:

Symptoms: Check (✓) symptoms you currently have or have had this year.

General

- ☐ Chills
- ☐ Fever
- ☐ Lifestyle change
- ☐ Malaise / Fatigue
- ☐ Weight gain or loss (unexplained)

Eyes, Ears, Nose, Throat

- ☐ Blurred Vision
- ☐ Hearing loss
- ☐ Double Vision
- ☐ Hay fever
- ☐ Cataracts
- ☐ Hoarseness
- ☐ Seeing flashes
- ☐ Gums bleeding
- ☐ Seeing halos
- ☐ Nosebleeds
- ☐ Earache
- ☐ Sinus problems
- ☐ Ear discharge
- ☐ Ears ringing
- ☐ Swallowing difficulty

Cardiovascular

- ☐ Ankles swelling
- ☐ Poor circulation
- ☐ Blood pressure
- ☐ Irregular heart beat
- ☐ High ☐ Low
- ☐ Rapid heart beat
- ☐ Chest pain
- ☐ Varicose veins
- ☐ Heart Disease
- ☐ Stroke

Respiratory

- ☐ Cough
- ☐ blood in sputum
- ☐ productive ☐ non-productive
- ☐ shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia

Gastrointestinal

- ☐ Appetite poor
- ☐ Gas
- ☐ Excessive hunger
- ☐ Hemorrhoids
- ☐ Bloating
- ☐ Indigestion
- ☐ Bowel changes
- ☐ Nausea
- ☐ Constipation
- ☐ Rectal bleeding
- ☐ Diarrhea
- ☐ Stomach pain
- ☐ Ulcer
- ☐ Vomiting

Genitourinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Urinate a lot at night
- ☐ Urgency

Muscle / Joint / Bone

☐ Pain ☐ weakness ☐ numbness

- ☐ Arm(s)
- ☐ Hip(s)
- ☐ Back
- ☐ Leg(s)
- ☐ Feet
- ☐ Neck
- ☐ Hand(s)
- ☐ Shoulder(s)
- ☐ Arthritis
- ☐ Gout

Emotional & Psychological status

- ☐ Anxiety
- ☐ Suicidal thoughts
- ☐ Depression
- ☐ Suicide Attempt
- ☐ Overactivity
- ☐ Obsessions
- ☐ Change in sleep pattern
- ☐ Compulsions

Nervous System

- ☐ Syncope
- ☐ Change in memory
- ☐ Seizure
- ☐ Tremor
- ☐ Dizziness

Skin

- ☐ Bruise easily
- ☐ Itching
- ☐ Change in mole(s)
- ☐ Rash
- ☐ Hives
- ☐ Sore that won't heal

Men (only)

- ☐ Breast lump / knot
- ☐ Penis discharge
- ☐ Erection difficulties
- ☐ Sore in penis
- ☐ Lump / knot in testicles
- ☐ Prostate problems
- ☐ Other _____

Women (only)

- ☐ Abnormal pap smear
- ☐ Painful intercourse
- ☐ Breast lump / knot
- ☐ Vaginal discharge
- ☐ Hot flashes
- ☐ Bleeding between periods
- ☐ Nipple discharge
- ☐ Extreme menstrual pain
- ☐ Other _____
- ☐ Miscarriage

Have you had a Hystectomy? ☐ Y ☐ N _____ (Date)

Date of last pap smear: _____

Date of last period: _____

Have you had a Mammogram? ☐ Y ☐ N

When? _____ Where? _____

Are you pregnant? ☐ Y ☐ N No. of children: ___

Conditions: Check (✓) symptoms you currently have or have had this year.

- ☐ AIDS
- ☐ Hernia
- ☐ Alcoholism
- ☐ Herpes
- ☐ Anemia
- ☐ High Cholesterol
- ☐ Anorexia
- ☐ HIV Positive
- ☐ Bleeding Disorder
- ☐ Kidney Disease
- ☐ Bulimia
- ☐ Liver Disease
- ☐ Cancer
- ☐ Migraine Headaches
- ☐ Diabetes
- ☐ Mononucleosis
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Glaucoma
- ☐ Psychiatric Care
- ☐ Gonorrhea
- ☐ Thyroid Care
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Chemical Dependency

Medications: List all medications you are currently taking. Please list over the counter medications as well.

Allergies: Please list any allergies to medications or substances you have

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Family History - Please fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

Check if your blood relatives had any of the following:

Disease	Relationship to You
☐ Arthritis, Gout	
☐ Asthma, Hay Fever	
☐ Cancer	
☐ Alcoholism	
☐ Diabetes	
☐ Heart Attack	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Stroke	
☐ Other	

Surgeries

Date	Hospital	Procedure & Outcome

Serious Illness / Injuries

Date	Illness / Injury	Outcome

Hospitalizations

Date	Hospital	Reason

Pregnancy History

Year	Sex of Child	Complications if Any

Other Physicians or Health Care Providers: Please list any other provider(s) you are currently seeing or have seen recently.

Date	Provider	Treatment / Condition	Date	Provider	Treatment / Condition

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, please give approximate date(s):_____

Health Habits: Please check if you use any of the following substances and describe how much you use:

☐ Caffeine -_____ ☐ Tobacco -_____ ☐ Drugs -_____ ☐ Alcohol -_____

Health Safety: Please check ones that apply to you:

☐ Seat Belts
☐ Helmet
☐ Bike ☐ Motorcycle

Sexually active? ☐ Y ☐ N
☐ Safe sex
Type of protection

☐ Do you exercise regularly? ☐ Yes ☐ No
How much?_____
How often?_____

Immunizations & approximate dates

☐ Flu Date_____
☐ Pneumovax Date_____
☐ Tetanus / Diphtheria Date_____
☐ PPD (TB skin test) Date_____

If child are immunizations up to date?
if needed where can these records be found (clinic or health facility)?

I certify that the above information is correct to the best of my knowledge. I will not hold Family Medical Group or any of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: Date:

Provider use only: Reviewed by: Date: Reviewed by: Date

Reviewed by: Date Reviewed by: Date