

# 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.

<b>General</b> <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Lifestyle change <input type="checkbox"/> Malaise / Fatigue <input type="checkbox"/> Weight gain or loss (unexplained)	<b>Gastrointestinal</b> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Gas <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Bloating <input type="checkbox"/> Indigestion <input type="checkbox"/> Bowel changes <input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Diarrhea <input type="checkbox"/> Stomach pain <input type="checkbox"/> Ulcer <input type="checkbox"/> Vomiting	<b>Nervous System</b> <input type="checkbox"/> Syncope <input type="checkbox"/> Change in memory <input type="checkbox"/> Seizure <input type="checkbox"/> Tremor <input type="checkbox"/> Dizziness
<b>Eyes, Ears, Nose, Throat</b> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Hearing loss <input type="checkbox"/> Double Vision <input type="checkbox"/> Hay fever <input type="checkbox"/> Cataracts <input type="checkbox"/> Hoarseness <input type="checkbox"/> Seeing flashes <input type="checkbox"/> Gums bleeding <input type="checkbox"/> Seeing halos <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Earache <input type="checkbox"/> Sinus problems <input type="checkbox"/> Ear discharge <input type="checkbox"/> Ears ringing <input type="checkbox"/> Swallowing difficulty	<b>Genitourinary</b> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Urinate a lot at night <input type="checkbox"/> Urgency	<b>Skin</b> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Itching <input type="checkbox"/> Change in mole(s) <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Sore that won't heal
<b>Cardiovascular</b> <input type="checkbox"/> Ankles swelling <input type="checkbox"/> Poor circulation <input type="checkbox"/> Blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Chest pain <input type="checkbox"/> Varicose veins <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke	<b>Muscle / Joint / Bone</b> <input type="checkbox"/> Pain <input type="checkbox"/> weakness <input type="checkbox"/> numbness <input type="checkbox"/> Arm(s) <input type="checkbox"/> Hip(s) <input type="checkbox"/> Back <input type="checkbox"/> Leg(s) <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hand(s) <input type="checkbox"/> Shoulder(s) <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout	<b>Men (only)</b> <input type="checkbox"/> Breast lump / knot <input type="checkbox"/> Penis discharge <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Sore in penis <input type="checkbox"/> Lump / knot in testicles <input type="checkbox"/> Prostate problems <input type="checkbox"/> Other _____
<b>Respiratory</b> <input type="checkbox"/> Cough <input type="checkbox"/> blood in sputum <input type="checkbox"/> productive <input type="checkbox"/> non-productive <input type="checkbox"/> shortness of breath <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia	<b>Emotional &amp; Psychological status</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Depression <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Overactivity <input type="checkbox"/> Obsessions <input type="checkbox"/> Change in sleep pattern <input type="checkbox"/> Compulsions	<b>Women (only)</b> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Breast lump / knot <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Hot flashes <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Other _____ <input type="checkbox"/> Miscarriage Have you had a Hystectomy? <input type="checkbox"/> Y <input type="checkbox"/> N _____ (Date)

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

- |                                              |                                             |
|----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Hernia             |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Herpes             |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> High Cholesterol   |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> HIV Positive       |
| <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> Kidney Disease     |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Liver Disease      |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mononucleosis      |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Psychiatric Care   |
| <input type="checkbox"/> Gonorrhoea          | <input type="checkbox"/> Thyroid Care       |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> 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

Check if your blood relatives had any of the following:

Relation	Age	State of Health	Age at Death	Cause of Death	Disease	Relationship to You
Father					<input type="checkbox"/> Arthritis, Gout	
Mother					<input type="checkbox"/> Asthma, Hay Fever	
Brother(s)					<input type="checkbox"/> Cancer	
					<input type="checkbox"/> Alcoholism	
					<input type="checkbox"/> Diabetes	
					<input type="checkbox"/> Heart Attack	
Sister(s)					<input type="checkbox"/> High Blood Pressure	
					<input type="checkbox"/> Kidney Disease	
					<input type="checkbox"/> Stroke	
					<input type="checkbox"/> Other	

**Surgeries**

Date	Hospital	Procedure & Outcome

**Hospitalizations**

Date	Hospital	Reason

**Serious Illness / Injuries**

Date	Illness / Injury	Outcome

**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                       Pneumovax                       Tetanus / Diphtheria                       PPD (TB skin test)

Date \_\_\_\_\_ Date \_\_\_\_\_                      Date \_\_\_\_\_                      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:

<b>Provider use only:</b> Reviewed by: _____ Date: _____		Reviewed by: _____ Date: _____	
Reviewed by: _____ Date: _____		Reviewed by: _____ Date: _____	