



Patient History Form

Name: _____ Chart #: _____
Date: _____
First Middle Last

DOB: _____ Sex: _____ Age: _____ Marital Status: S M W D
(Circle One)

Height: _____ Weight: _____ Occupation: _____

Primary Physician: _____

Chief Complaint: _____

Any Known Drug Allergies: _____

List Current Medications: _____

Family History:

Father: _____ Living _____ Decreased
Mother: _____ Living _____ Decreased
Siblings: _____ # Living _____ # Decreased

Children: _____ # Living _____ # Decreased

Do You have a Family History of:

Heart Disease No Yes
High Blood Pressure No Yes
Diabetes No Yes
Stroke No Yes
Cancer (Location) No Yes
Thyroid Disease No Yes
Other: _____

Cause of Death:

Family Member:

WITHIN THE PAST 6 MONTHS Have you had any of the following?

Ulcers No Yes
Colitis No Yes
Rectal Bleeding No Yes
Change in Bowel Habits No Yes
Black Tarry Stools No Yes
Heart Disease No Yes
High Blood Pressure No Yes
Chest Pain No Yes
Cough Blood No Yes

Please Explain:

Shortness of Breath	No	Yes	_____
Thyroid Disease	No	Yes	_____
Lung Disease	No	Yes	_____
Cancer(Location)	No	Yes	_____
Asthma or Emphysema	No	Yes	_____
Hepatitis	No	Yes	_____
Jaundice or Liver Disease	No	Yes	_____
Gallbladder Disease	No	Yes	_____
Venereal Disease	No	Yes	_____
Kidney Stone(s)	No	Yes	_____
Blood in Urine	No	Yes	_____
Epilepsy	No	Yes	_____
Swollen or Painful Joints	No	Yes	_____
Nervous Disorder	No	Yes	_____
Depression	No	Yes	_____
Diabetes	No	Yes	_____
Stroke	No	Yes	_____
Back Disorder	No	Yes	_____
Blood Disease or Anemia	No	Yes	_____

Personal History

	Year	Hospital
Illnesses	_____	_____
	_____	_____
	_____	_____
Surgeries	_____	_____
	_____	_____
	_____	_____

Do you?

	No	Yes	Please Explain
Regularly Exercise (3 to 4 times a week)	No	Yes	_____
Wear Auto Seat Belts (90% of the time)	No	Yes	_____
Use Illegal Drugs	No	Yes	_____
Use Alcohol	No	Yes	_____
Were You Ever a Heavy Drinker	No	Yes	_____
Smoke (if you quit, give date)	No	Yes	_____

Women Only

Menstrual Cycle: Are Periods Regular?	No	Yes	Date of Last Period? _____
Age Onset: _____	Do You Have Difficulties With Periods?		_____
Pregnancies:	Describe Any Complications		
_____ # Born Natural	_____		
_____ # Cesarean Sections(s)	_____		
_____ # Premature(s)	_____		
_____ # Stillborn(s)	_____		
_____ # Miscarriage(s)	_____		