

Physicians Medical Center

PATIENT HISTORY FORM

Patient's Name: _____ DOB: _____ Date: _____

Briefly Describe What Problem Brings you to the Doctor: _____

List All Your Medications: (Including: The Dosage, Frequency, and Any Non-Prescription Medications you take, such as: Vitamins, Calcium, Aspirin, etc.)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Medication Allergies

- | |
|----------|
| 1. _____ |
| 2. _____ |
| 3. _____ |
| 4. _____ |
| 5. _____ |

Past Medical History: Please Place a Check Mark, and indicate year, If You or Your Family Ever Had any of the Following.

- | | | | |
|---------------------------------------|--|---|--|
| 1. Diabetes: <input type="checkbox"/> | 5. Psychiatric Problem: <input type="checkbox"/> | 9. Heart Disease: <input type="checkbox"/> | 13. Liver Function: <input type="checkbox"/> |
| 2. Thyroid: <input type="checkbox"/> | 6. High Blood Pressure: <input type="checkbox"/> | 10. Urine Infection: <input type="checkbox"/> | 14. Kidney Disease: <input type="checkbox"/> |
| 3. Seizures: <input type="checkbox"/> | 7. Lung Disease: <input type="checkbox"/> | 11. Bleeding Problems: <input type="checkbox"/> | 15. Infertility: <input type="checkbox"/> |
| 4. T/B: <input type="checkbox"/> | 8. Kidney Stones: <input type="checkbox"/> | 12. Anesthesia Problems: <input type="checkbox"/> | 16. Cancer: <input type="checkbox"/> |

Other _____

Type of Cancer? _____

Past Gynecological History: 1. Last Menstrual Period _____ 2. # of Pregnancies _____ 3. Live Births _____

Past Surgical History:

Surgery	Date	Surgery	Date
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Previous Hospitalizations:

Year	City/Hospital	Reason	Doctor
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Immunizations: Last Tetanus Shot: _____ Pneumonia Vaccine: _____ Flu Shot: _____

If patient is a child, are immunizations up to date? _____

Date of Last Mammogram: _____ **Date of Last DexaScan:** _____ **Date of Last Colonoscopy:** _____

Family Medical History:

Disease or Cause of Death

1. Father Age _____ Living Deceased _____

2. Mother Age _____ Living Deceased _____

3. Brother Age _____ Living Deceased _____

4. Brother Age _____ Living Deceased _____

5. Sister Age _____ Living Deceased _____

6. Sister Age _____ Living Deceased _____

Social History:

Single Married
 Divorced Widowed

Do you or Have you Ever

Used Tobacco? Yes No
 If Yes, How Much? _____
 If Quit, When? _____

Used Alcohol? Yes No
 If Yes, How Much? _____
 If Quit, When? _____

Used Caffeine? Yes No

Review of Systems:Do You Now or Have You Recently Had Problems With Any of the Following?**(Please Circle Your Answer)**

G/U Sytem: Pain Or Burning With Urination Kidney Stone Frequency Slow Or Small Stream Blood in the Urine
 Getting Up At Night to Urinate Leaking Urine Urgency Poor Bladder Emptying Recurrent Urine Infections
 Abnormal Vaginal Bleeding Sexual Problem Menstrual Problems

General: Change in Weight Fever Fatigue

Skin: Lumps or Nodules Breast Lump Rashes Sores Other Skin Problems

Eyes: Glaucoma Cataracts Glasses Other Eye Problems

Heme/Lymph: Swollen Nodes or Glands Bleeding Issues Anemia Other Blood Disorders

C/V: Irregular Heart Beat Heart Failure Angina Heart Valve Problems Heart Murmur
 Pain in Legs With Exertion Chest Pain Phlebitis Swelling in Legs Blood Clots
 Other Heart/Blood Vessel Problems

Neuro: Loss of Consciousness Headaches Stokes Dizziness Paralysis
 Numbness Weakness

Psych: Other Psychological Problems Depression Anxiety

Musculoskeletal: Joint Replacement Surgery Broken Bones Gout Arthritis Bone or Joint Pain

Endocrine: Heat or Cold Intolerance Hot Flashes Flushing Abnormally Thirsty Changes in Body Hair
 Skin Pigmentation Changes

G/I: Heartburn Indigestion Pain Nausea-Vomiting Stool Problem
 Blood

Pulmonary: Cough Pain Blood Shortness of Breath Regular Sputum

Nose/Throat: Bleeding Pain Voice Change Difficult Swallowing Mouth

Hearing: Hearing Aids Yes / No Loss Ringing Pain Dizzy
 Vertigo

Consultants/Other Physicians:

Optometry: _____

Ophthalmology: _____

GYN: _____

Other: _____

Patient's Signature

