

PATIENT HISTORY

Name: _____ Age: _____ Date: _____

Social History: Tobacco Y/N # of packs/day _____ Alcohol: Y/N # /day or week _____
Street drugs: Y/N Type: _____ Date last used: _____
Other: _____

Family History: Check all abnormals and write which family members:

_____ Heart disease _____	_____ Lung disease (tuberculosis) _____
_____ Neurologic disease _____	_____ High blood pressure _____
_____ Blood disease _____	_____ Psychiatric illness _____
_____ Kidney disease _____	_____ Birth defects/handicaps _____
_____ Glaucoma _____	_____ Elevated cholesterol _____
_____ Thyroid disease _____	_____ Epilepsy (seizure disorder) _____
_____ Lung disease _____	_____ Diabetes _____
_____ Liver disease or hepatitis _____	_____ Phlebitis (blood clots) _____
_____ Colon cancer _____	_____ Stroke _____
_____ Breast cancer _____	_____ Gastrointestinal disease _____
_____ Ovarian cancer _____	_____ Endometriosis _____
_____ Cervical cancer _____	_____ Other illness or diseases _____
_____ Other cancers _____	

Please list ALLERGIES: _____

Please list the medications you are currently take:

Review of systems: Check if you are currently having any of these problems:

_____ Fever	_____ Constipation	_____ Abnormal weight loss/gain
_____ Nausea/vomiting	_____ Visual changes	_____ Pelvic pain
_____ Cold symptoms	_____ Burning w/urination	_____ Sore throat
_____ Vaginal discharge	_____ Hearing loss	_____ Incontinence (loss or urine)
_____ Chest pain	_____ Joint pain	_____ Irregular heart beat
_____ Muscle weakness	_____ Shortness of breath	_____ Tremors
_____ Cough	_____ Numbness	_____ Diarrhea
_____ Lumps/swelling in breast, Groin, arm pits or neck	_____ Bruise easily	_____ Headaches
_____ Unusual hair growth/loss	_____ Hot flashes	_____ Blood in bowel movements
_____ Blood in urine		
_____ Other		

Patient Signature: _____

Nurses Signature: _____