MRN: _____

PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

Preferred Pharmacy: _____

Pharmacy Phone Number: (423)_____-_____

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other Physicans you currently see and reason:

Psychiatric Hospitalizations (include where, when, & for what reason):

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes

Please list allergies and reactions:

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Do you use tobacco products?
❑ Yes ❑ No ❑ Past
Cigarettes per day? _____
How many years have or did you us
tobacco? _____

Physician initials _____

MRN: _____

Ever /diagnosed treated for a sexually transmitted disease or infection (STD/STI)? _____

Up to Date for Vaccines: Y/N or N/A (If yes, give approximate dates)
Flu: _____ Tetanus: _____
Pneumonia: _____ (Prevnar 13 and/or Pneumovax?)
Shingles: _____
Other: _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism/Hyperthyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis/Eczema
- ❑ Angina
- ❑ Heart problems
- ❑ Heart Attack/Stroke
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema/COPD
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Gout
- ❑ Crohn's disease
- ❑ Colitis/IBS/Diverticulitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Heartburn/Reflux
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Blood Disorder
- ❑ Rheumatic fever

Other medical conditions (please list):

_____

_____

_____

SURGICAL HISTORY

Please list all surgeries and approximate dates:

PERSONAL HISTORY

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? ❑ Yes ❑ No Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long? _____

Have you ever had legal problems? (specify)

Religion:

Physician initials _____

FAMILY HISTORY

Have any members of your immediate family (parents, siblings, grandparents, children) ever had:

Breast Cancer:	❑ Yes	❑ No	If so, whom? _____
Colon Cancer:	❑ Yes	❑ No	If so, whom? _____
Other types of cancer:	❑ Yes	❑ No	If so, whom? _____
High blood pressure:	❑ Yes	❑ No	If so, whom? _____
Stroke:	❑ Yes	❑ No	If so, whom? _____
Heart problems:	❑ Yes	❑ No	If so, whom? _____
Diabetes:	❑ Yes	❑ No	If so, whom? _____

AGE:_____
AGE:_____

TYPE 1/TYPE 2

Any family psychiatric disorders that have been treated for depression, anxiety, bipolar disorder, personality disorder, schizophrenia, or any other mental illness? If so, whom and what disorder(s)? _____

_____

Have you ever had ECT? _____ Have you had psychotherapy? _____

Any family history with Parkinson's disease or dementia such as Alzheimer's? If so, whom and what disorder(s)? At what age were they diagnosed?_____

Other Family History ?

_____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS

NERVOUS SYSTEM
- ❑ Headaches/Migraines
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations

Physician initials _____

❑ Ringing in ears
❑ Loss of hearing
❑ Ear Wax Impactions
❑ Hearings Aids: R/L/Both

❑ Blood in stools
❑ Black stools
❑ Colonoscopy: _____
❑ EGD/Scope: _____

❑ Rapid speech
❑ Guilty thoughts
❑ Paranoia
❑ Mood swings
❑ Anxiety
❑ Risky behavior

EYES
❑ Pain
❑ Redness
❑ Loss of vision
❑ Double or blurred vision
❑ Dryness
❑ Last eye exam: _____

SKIN
❑ Redness
❑ Rash
❑ Nodules/bumps
❑ Hair loss
❑ Color changes of hands or feet

HEART AND LUNGS
❑ Chest pain
❑ Palpitations
❑ Shortness of breath
❑ Fainting
❑ Swollen legs or feet
❑ Cough

THROAT
❑ Frequent sore throats
❑ Hoarseness
❑ Difficulty in swallowing
❑ Pain in jaw
❑ Last dental visit: _____

BLOOD
❑ Anemia
❑ Clots

OTHER PROBLEMS:
_____
_____
_____
_____

KIDNEY/URINE/BLADDER
❑ Frequent or painful urination
❑ Blood in urine
❑ Chronic UTIs

PEDIATRIC HISTORY (ONLY FOR THOSE 18 & YOUNGER):
Hospital of birth? _____ Full term? Y/N If no, how many weeks early? _____ Vaginal/C-Section
Vaccinations permissible? _____ If so, vaccines up to date? Y/N (Please provide vaccine record)
Any known developmental delays? _____
Any concerns about your child's development?_____

WOMENS REPRODUCTIVE HISTORY:
Age of first period: _____ Last period: _____ Do you have regular periods: Y/N
Last pap smear: _____ Abnormal Pap Smear: Y/N If so, when: _____
Pregnancies: _____ Any reproductive surgeries performed, excluding c-sections? Y/N
Miscarriages: _____ If yes,_____
Abortions: _____
Number of Children Living: _____ Currently pregnant or nursing? _____
Ever diagnosed/treated for post-partum depression? Y/N If yes,_____
Have you reached menopause? Y / N At what age? _____ Taking HRT: Y/N Kind: _____
Last mammogram: _____ Abnormal Mammogram Results: _____

Physician initials _____