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PATIENT HISTORY FORM

Last name:	First name:	MI	Date of Birth:	Age:
Marital Status: Single. Divorced. Married. Widow/er			Who lives with you?	
Employer:	Occupation	What kind of work?		
Primary care physician			Other doctors involved with your case:	

REVIEW OF SYSTEMS

Have you or the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Is your family physician aware of any symptoms/illness that you have checked below? Yes No

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	Medical History	NO	YES
Gastrointestinal			Cardiac			Neurology			Hypertension		
Abdominal pain			High blood pressure			Dizziness			Diabetes Mellitus		
Nausea/vomiting			Low blood pressure			Headache			Heart Disease/CAD		
Heartburn			Irregular heartbeat			Musculoskeletal			COPD/Emphysema		
Diarrhea			Chest pain			Muscle pain			Renal Disease		
Constipation			Respiratory			Arthritic pain			High Cholesterol		
Change in BMs			Asthma			Neck/ Back pain			Hypothyroidism		
Rectal bleeding/ pain			Bronchitis			Blood disorders			Hyperthyroidism		
Trouble swallowing			Difficult breathing			Blood transfusion			Arthritis		
Bloating			Chronic cough			DVT/ Blood clot			Crohn's Disease		
Endocrine/Metabolic			Hoarseness			Skin			Ulcerative Colitis		
Fatigue			Genitourinary			Rash			IBS/ Spastic colon		
Excessive fluid intake			Painful urination			Bruises			Colon Polyps		
Hair change			Frequent urination			Tattoos			Pancreatitis		
Heat intolerance			Discharge			Psychosocial			Liver Disease		
Ear, Nose & Throat			Abnormal menses (fem)			Alcoholism			Gallstone Disease		
Earache			Constitutional			Substance abuse			Cancer type		
Nosebleed			Fever			Depression			Others list below:		
			Weight loss			Anxiety disorder					

PAST HISTORY

Please explain any YES answers in detailed description in the box provided

Have you ever had any surgery or been hospitalized?	No	Yes	Surgeries	Dates	Hospitalization other than surgery	Dates		
Have you had any problems with anesthesia?	No	Yes						
Are you currently or have you ever used any tobacco or alcohol products?	No	Yes	Alcohol: How many drinks: per day ____ week ____ month ____					
			Tobacco: How many packs per day ____ week ____ month ____					
Are you or have you ever used recreational or illicit drugs?	No	Yes	If yes what kind?					
			For how long?					
Are you currently taking any medication or drugs? (including over-the-counter, prescription, birth control pills)?	No	Yes	Medication	Dose	Times	Medication	Dose	Times
Do you have any allergies (including environmental, medication, food and reaction to previous blood transfusion)?	No	Yes	List Allergies:					

FAMILY HISTORY:

Please indicate if your parents, brothers, sisters and /or children have had any of the following conditions.

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Colon/Rectal Cancer		Crohn's / UC		Heart disease	
No ____ Yes ____		No ____ Yes ____		No ____ Yes ____	
Stomach Ca		Renal disease		Diabetes Mellitus	
No ____ Yes ____		No ____ Yes ____		No ____ Yes ____	
Colon Polyps		Breast/Ovary Cancer		Liver cirrhosis	
No ____ Yes ____		No ____ Yes ____		No ____ Yes ____	

Patients Signature _____

Reviewed by Provider _____

Date _____