Patient History form

Name: _____ DOB: _____ Date: _____

Family history: (Please check the appropriate box if any pertain) ☐ Unknown

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Arthritis	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐

Social History:

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Prefer not to report
Tobacco: ☐ None user ☐ Tobacco User ☐ Prefer not to report
Alcohol usage: ☐ None user ☐ Alcohol User ☐ Prefer not to report
Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Prefer not to report
Work Activities: ☐ Sitting ☐ Computer Based ☐ Heavy Labor ☐ Light Labor ☐ Standing ☐ Prefer not to report
Exercise: ☐ Frequently ☐ Moderately ☐ Occasionally ☐ Do not exercise ☐ Prefer not to report

Past Medical History: **Please check to indicate if you have ever had any of the following:**

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia/ Bulimia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Congenital Heart defect
- ❑ Depression
- ❑ Difficulty Breathing
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Heart Attack/ Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles/ Mumps
- ❑ Migraines
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempts
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Other _____

Please list all current medications: _____ ☐ I am not on medication

_____

_____

_____

_____

List past surgery(ies) or hospitalization and date: _____

_____

_____

Are you currently or possibly pregnant; trying to become pregnant or nursing? ☐ Yes ☐ No

General Allergies: ☐ Animals ☐ Bee stings ☐ Gluten ☐ Latex ☐ Peanut ☐ Seasonal ☐ Seafood
Drug Allergies: ☐ none known ☐ _____

_____

MIPS (required federal reporting):

Do you consume more than 5+ drinks (men)/ 4+ drinks (woman) a day more than twice a year? ☐ Yes ☐ No ☐ Prefer not to say

Do you have concerns about being depressed? ☐ Yes ☐ No ☐ I am currently being treated for depression ☐ Prefer not to report

Have you had a flu shot since August 1, 2016? ☐ I declined immunization or not received ☐ Yes ☐ Prefer not to report