Patient History Form

Today's Date ______/_____/_____ Date of Last Physical Exam _____/_____/_____

Patient information

First Name _________________________ Middle Initial ____ Last Name _______________________________
Address __________________________________ Apt # _____ City _____________ State _____ Zip _______

Telephone (______) ______-______ Mobile # (______) ______-______ E-Mail ______________________

Date of Birth _____/_____/_____ Age _____ Height _____ Weight _____ SS# _____-_____-_____

Emergency Contact________________________________ Telephone (______) ______-______

Patient's Employer _________________________________ Employer's Telephone (_____) _____ - ______

Spouse's Name _______________________ If patient is a minor, Parent's name ______________________

Medical History

Have you had any of the following:

Anemia	_____	Gallbladder Problems	_____	Malaria	_____	Ulcers	_____
Arthritis	_____	Heart Problems	_____	Measels	_____	Thyroid (Goiter)	_____
Asthma	_____	Hemorroids	_____	Mumps	_____	Tonsillitis	_____
Blood Disease	_____	Hepatitis	_____	Nervous/Emotional Breakdown	_____	Tuberculosis	_____
Cancer	_____	Hernia	_____	Pleurisy	_____	Typhoid	_____
Chickenpox	_____	Herpes	_____	Pneumonia	_____	Varicose Veins	_____
Circulation Problems	_____	High/Low Blood Pressure	_____	Scarlet Fever	_____	Venereal Disease	_____
Convulsions/ Epilepsy	_____	Kidney Problems	_____	Stomach	_____	Whooping Cough	____
				Liver problem	_____	Diabetes	_____
						Other ______________________	

Do you have a disability? _____ Yes _____No If yes, describe: ____________________________________

FEMALE: Age of First Menstrual Period __________ Date of Last Menstrual Period _____/_____/_____

# of Days Between Periods _____ Menstrual Cramps ___ Yes ___ No Date of Last Pap Smear___/___/___

Date of Last Mammogram ____/____/____ Type of Contraception___________ Postmenopausal __Yes __No

MALE: Penal Discharge ___Yes ___No

ADULT IMMUNIZATIONS: Flu ___/___/___Pneumonia ___/___/___ Tetanus ___/___/___ Other ___/___/___

CHILD IMMUNIZATIONS: (Please submit your Immunization Records with this form)

Are they Current? ___Yes ___No DPT _____/____/____ Polio _____/_____/_____

MMR ____/____/____ TB Test ____/____/____ Chickenpox ____/____/____ HIB ____/____/____

HEPATITIS: ___ Yes ___ No If yes, Hepatitis A ____/____/____ or Hepatitis B ____/____/____
If Hepatitis B, have you had the 3 shot series? ____ Yes ____No

Medical History (continued)

Illnesses/Injuries/Surgeries **Date**

____ __________

____ __________

____ __________

____ __________

List Allergies (medication, food, etc.)

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

Social History

Have you ever smoked ___ Yes ___ No If yes, how much______ How long _____ When did you quit_______

Do you drink alcoholic beverages ___ Yes ___ No If yes, how often and much ______________________

Do you exercise ___Yes ____ No If yes, how often? ____________ How long? ___________
Advanced Directive _____ Yes _____No Tattoo's _____ Yes _____No

Family History

List which of your family is living or deceased and their medical condition(s):

Relative	Living/Deceased	Sex	Age	Cause of Death	Medical Conditions
Father					
Mother					
Sibling					
Sibling					
Sibling					

Have any of your family members had any of the following medical conditions?

AIDS _____
Allergies _____
Anemia/ Bleeding _____
Arthritis _____
Cancer _____
Chronic Cough_____
Diabetes _____
Convulsions/ Epilepsy _____
Heart Disease _____
Hepatitis _____
Herpes _____
High Blood Pressure _____
Kidney Disease ____
Migrane _____
Nervous/Emotional Breakdown _____
Obesity _____
Paralysis/Stroke _____
Rheumatism _____
Rheumatic Fever _____
Tuberculosis _____
Venereal Disease _____
Other _____________
____
____
____

THIS IS A CONFIDENTIAL RECORDS AND WILL BE KEPT AT **HealthCareClinics** IN YOUR FILE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

Patient Signature ____ Date ____/____/____
Medical Assistant Signature ________________________________ Date ____/____/____
Physician/FNP/PA-C _______________________________________ Date ____/____/____