

DO NOT WRITE IN THIS BOX

NURSE DATA: BP: _____ Pulse: _____ Wt.: _____ Blood Sugar: _____

PATIENT HISTORY FORM

Name: _____ Date: _____

Age: _____ Height: _____

Reason for Visit: _____

Medication (name, dosage and how often taken):

Vitamins / Supplements: _____

Allergies to Medications: _____

PAST MEDICAL HISTORY - Check any that you have ever had

- Thyroid:**
- Hypothyroid/Underactive
 - Hyperthyroid/Overactive
 - Thyroid Cancer
 - Thyroid Nodule

- Diabetes:**
- Your Age at Diagnosis _____
 - Retinopathy
 - Laser needed
 - Neuropathy
 - Increased Urine Protein

- Heart:**
- Heart Attack / MI
 - Heart Failure
 - Atrial Fibrillations
 - Elevated Cholesterol
 - Angioplasty / Stent
 - Stroke
 - High Blood Pressure

- Cancer of:**
- Lung
 - Colon
 - Prostate
 - Breast
 - Other: _____

- Lung:**
- Asthma
 - COPD/Emphysema
 - Sleep Apnea
 - Other: _____

- Bone:**
- Osteoporosis/Osteopenia
 - Hip Fracture
 - Spine Fracture
 - Wrist Fracture
 - Other: _____

- Liver/
Stomach:**
- Chronic Hepatitis
 - Celiac Disease
 - Gallstones
 - GERD / Reflux
 - Other: _____

- Kidney
Disease:**
- Frequent Infections
 - Impaired Function
 - Dialysis
 - Kidney Stones
 - Other: _____

- Brain or
Nervous
Disorders**
- Seizures
 - Neuropathy
 - Stroke
 - Other: _____

Other Major Medical Problems: _____

- Surgeries:**
- No surgeries
 - Hernia When: _____
 - Hip Replacement When: _____
 - Leg Bypass When: _____
 - Heart Bypass When: _____
 - Angioplasty / Stent When: _____
 - Hysterectomy When: _____
 - Carotid Surgery When: _____
 - Gallbladder When: _____
 - Tubal Ligation When: _____
 - Any Other Surgery (Describe) _____ When: _____

FAMILY HISTORY (parents, grandparents, siblings, children)

High Blood Pressure: _____
Heart Attack: _____
Stroke: _____

Diabetes: Adult Onset/Type 2: _____
Juvenile Onset/Type 1: _____

Thyroid: Hypothyroid / Underactive: _____
Thyroid Nodules: _____
Gout: _____

Cancer / Type: _____
Other Diseases that run in your family: _____

SOCIAL HISTORY

Occupation: _____
Marital Status: _____ # of children: _____

Smoking Yes No Type / Amount: _____
Alcohol Yes No Frequency: _____
Exercise Yes No Habits: _____
Special Diet Yes No Restrictions: _____

REVIEW OF SYSTEMS (Circle if you **CURRENTLY** have problems with)

General: Weight Loss (_____ lbs. over _____ months/years) / Weight Gain (_____ lbs. over _____ months/years) / Fatigue / Insomnia
HENT: Persistent Hoarseness / Voice weakness / Loud Snoring

HEME: Easy Bruising / Anemia

Endocrine: Excessive Thirst / Excessive Urination / Urination at Night - How many times? _____ / Sensitive to cold temperature / Sensitive to hot temperature / Breast Growth (men) / Breast Discharge / Poor Libido

Gynecological: Irregular Periods / Heavy Periods / Infertility / Post-menopausal
Urinary: Erectile Dysfunction / Poor Stream / Incomplete Urination / Frequent Urination/
Pain with Urination

Heart: Chest Pain or Pressure / Leg Swelling / Shortness of Breath / Palpitations /
Awakening Short of Breath at Night

Lungs: Wheezing / Cough / Shortness of Breath

Gastrointestinal: Constipation / Diarrhea / Heart Burn / Stomach Pain / Vomiting / Nausea

Skin: Excessive Acne / Excessive Hair Growth (women) / Hair Loss (women) / Vitiligo

Neurologic: Numbness of _____ / Frequent Headaches / Migraines / Tingling or Burning Pain in Feet /
Tingling or Burning Pain in Hands

Musculoskeletal: Arthritis / Back Pain / Joint Swelling or Stiffness / Fractures - of What? _____

Eye: Double Vision / Glaucoma / Impaired Vision

Psychiatric: Depression requiring treatment / Anxiety requiring treatment