



## PATIENT HISTORY FORM

**PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT**

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date you are filling out this form: \_\_\_\_\_

Who was your most recent physician/ primary care provider? Dr. \_\_\_\_\_

### TELL US ABOUT YOUR FAMILY

#### Parents/Guardians:

Names: Mother \_\_\_\_\_ Father \_\_\_\_\_

Address: \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_

Work/ cell phone \_\_\_\_\_

Occupation: \_\_\_\_\_

#### Parent/ Guardian Employment:

Status: full-time \_\_\_\_\_ part-time \_\_\_\_\_ retired \_\_\_\_\_ disabled \_\_\_\_\_ homemaker \_\_\_\_\_

Single \_\_\_\_\_ Married (how long \_\_\_\_\_) Divorced (how long \_\_\_\_\_)

Widowed (how long \_\_\_\_\_) Domestic partnership \_\_\_\_\_

Siblings? \_\_\_\_\_ Are they healthy? \_\_\_\_\_





## SYMPTOM REVIEW

### Gastrointestinal

- poor appetite
- abdominal pain
- indigestion
- trouble swallowing
- diarrhea
- constipation
- change in bowel habits
- nausea or vomiting
- rectal bleeding or blood in stools
- history of liver disease or abnormal liver tests

### Cardiovascular

- chest pain
- history of high blood pressure
- history of irregular beat
- history of poor circulation

### Pulmonary/lungs

- shortness of breath
- persistent cough
- coughing up blood
- asthma or wheezing

### Muscle/joint/bone

- swelling of ankles or legs  
pain, weakness or numbness in
- arms or hands
- back or hips
- legs or feet
- neck or shoulders

### Neurologic

- history of seizure
- blackouts or loss of consciousness
- history cerebral palsy
- prematurity with developmental delay

### Anything else?

- Are you experiencing an unusually stressful situation?
- Are there any specific personal issues you would like to bring up at the time of your visit?

### General

- weight gain/loss of 10+ lbs during last 6 months
- poor sleep
- fever
- headache
- depression

### Eyes, ears, nose, throat

- blurred vision
- other change in vision
- history of glaucoma or cataracts
- loss of hearing
- ringing in ears
- sinus problems
- persistent hoarseness

### Genitourinary

- frequent or painful urination
- blood in urine

### Skin

- itching
- easy bruising
- change in moles

### Endocrine

- history of diabetes
- history of thyroid disease
- change in tolerance to hot or cold weather
- excessive thirst

### Girls

- abnormal menstrual bleeding
- persistent bed wetting past age 6 years
- frequent fecal soiling in underwear

### Boys

- persistent bed wetting past age 6 years
- frequent fecal soiling in underwear

**Immunizations:** if YES, give approximate year given

Pneumococcal	No_____	Yes_____
Hepatitis A	No_____	Yes_____
Hepatitis B	No_____	Yes_____
Tetanus	No_____	Yes_____
MMR	No_____	Yes_____
Meningococcal	No_____	Yes_____
Chicken pox	No_____	Yes_____
Gardasil	No_____	Yes_____

Do you use seatbelt/carseat? No\_\_\_\_\_ Yes\_\_\_\_\_

**Transfusions:** Have you ever received a blood transfusion? No\_\_\_\_\_ Yes\_\_\_\_\_

If so, when?\_\_\_\_\_

**PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT**