

Patient History

Patient Name: _____

Date of Birth ____/____/____ Age _____ Height _____ Weight _____

Marital Status: Married Partner Single Divorced Widowed

Gender Identity (please circle): Male Female Transgender Female to Male Transgender Male to Female Genderqueer
 Choose not to disclose

Preferred Pronouns: She/Her He/Him They/Them

Please describe the nature of your issue:

PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED (PLEASE PRINT NEATLY), or if none please circle: None

If you need more space for your medications, please provide a list on a separate sheet

Name, dose (i.e., 2 mg, 60 mg, etc)	Frequency (i.e. twice daily, at bedtime)	Problem being treated Prescribing Doctor

ALLERGIES:

Are you allergic to ANY medication, food, or non-medications (such as pollen, etc.)? **No Yes**

If yes, please list below. Name of Medication / Food / Agent Type of Reaction, i.e. rash, breathing problems, swelling, etc

Metal Allergy: Y or N **Latex Allergy:** Y or N

PAST MEDICAL HISTORY

Please box next to any condition with which YOU have been diagnosed, or list other:

Medical	Medical	Neurological	Pertinent to Surgery
<input type="checkbox"/> None	<input type="checkbox"/> GERD / Reflux	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Anticoagulation
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> CVA/Stroke	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Brain Tumor	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hydrocephalus	<input type="checkbox"/> Clotting Disorder
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> HIV	<input type="checkbox"/> Migraines	<input type="checkbox"/> DVT
<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> High cholesterol/lipids	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Enlarged Prostate	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Narcotic use > 6 mo
<input type="checkbox"/> Cancer – Breast	<input type="checkbox"/> Irritable bowel disease	<input type="checkbox"/> Peripheral Neuropathy	<input type="checkbox"/> Anesthesia Problems
<input type="checkbox"/> Cancer – Lung	<input type="checkbox"/> Myocardial infarction	<input type="checkbox"/> Pituitary Tumor	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Cancer – Renal	<input type="checkbox"/> Nasal Allergies	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Other:
<input type="checkbox"/> Cancer – Colon	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Spinal Cord Injury	
<input type="checkbox"/> Cancer – Prostate	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> TIA	
<input type="checkbox"/> COPD	<input type="checkbox"/> Renal Disease	<input type="checkbox"/> Traumatic Brain Injury	
<input type="checkbox"/> Depression	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Trigeminal Neuralgia	
<input type="checkbox"/> Diabetes – Type I	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Other:	
<input type="checkbox"/> Diabetes – Type 2	<input type="checkbox"/> Vision Loss		
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Other:		

SURGERIES:

Have you ever had surgery? No Yes

If yes, list name / type of surgeries and when they were done.

FAMILY HISTORY

Please place ✓ in box and indicate which a member of your immediate family (i.e., mother, father, brother, sister) has been diagnosed:

Unknown Adopted None

<input type="checkbox"/> FH Alcoholism	<input type="checkbox"/> FH Breast Cancer	<input type="checkbox"/> FH High Blood Pressure	<input type="checkbox"/> FH Ovarian Cancer
<input type="checkbox"/> FH Anemia	<input type="checkbox"/> FH Cervical Cancer	<input type="checkbox"/> FH High Cholesterol	<input type="checkbox"/> FH Psychiatric Care
<input type="checkbox"/> FH Angina	<input type="checkbox"/> FH Colon Cancer	<input type="checkbox"/> FH Kidney Disease	<input type="checkbox"/> FH Respiratory Disease
<input type="checkbox"/> FH Arthritis	<input type="checkbox"/> FH Depression	<input type="checkbox"/> FH Liver Disease	<input type="checkbox"/> FH Seizures
<input type="checkbox"/> FH Asthma	<input type="checkbox"/> FH Diabetes	<input type="checkbox"/> FH Lung Cancer	<input type="checkbox"/> FH Severe Allergies
<input type="checkbox"/> FH Birth Defects	<input type="checkbox"/> FH Growth Problems	<input type="checkbox"/> FH Skin Cancer	<input type="checkbox"/> FH Stroke
<input type="checkbox"/> FH Blood Clots	<input type="checkbox"/> FH Headaches	<input type="checkbox"/> FH Osteoporosis	<input type="checkbox"/> FH Thyroid Disease
<input type="checkbox"/> FH Bowel Disease	<input type="checkbox"/> FH Heart Disease	<input type="checkbox"/> FH Other Cancer	<input type="checkbox"/> FH Uterine Cancer

SOCIAL HISTORY

Do you currently smoke / use tobacco in any form? No Yes

If yes, do you smoke or chew tobacco: _____

If yes, have you tried a smoking cessation or counseling program _____

Do you have a history of smoking/tobacco use? ... No Yes

If yes, when did you quit? _____

Do you currently drink alcohol? No Yes

If yes, please list how much a week: _____

Do you have history of alcohol abuse? No Yes

If yes, when did you quit? _____

Do you currently use any recreational drugs: No Yes

If yes, what type and how often: _____

PREVENTATIVE CARE

Have you had a colonoscopy (over age 55)? Y or N When? _____ Results? _____

Have you had a pneumonia vaccine (over age 65)? Y or N When? _____

Have you had any falls over the past year? Y or N How many? _____

Did you sustain an injury?: _____

Cause of fall? (Medical condition, environment- stairs, loose rug, etc) _____

Female Patients ONLY:

Date of last menstruation (approximate): _____

Pregnant: Yes _____ No _____ Unsure _____ Prefer not to answer _____

Breast feeding: Yes _____ No _____

Primary Care Physician Information

Name: _____ Phone: _____

Address: _____

Pharmacy Information:

Name: _____ Phone : _____

Address: _____

How did you hear about us? Circle any that apply:

Insurance Company Friend/Family/Word of Mouth Internet Search Engine Physician Referral Referral Mailers

Physician Referral (please specify) _____

Other: _____