
Patient History Form

DATE: _____

NAME: _____ HEIGHT: ____ WEIGHT: ____ AGE: _____

PRESENT ILLNESS: Please describe in your own words your present problem.

PAST MEDICAL HISTORY: Please indicate if you have (or ever had) any of the following illness. Give details in next section.

Anemia	___	Kidney Disease	___	Sinus problems	___	Cancer	___
Liver Disease	___	Stroke	___	Diabetes	___	Meningitis	___
Syphilis	___	Heart Disease	___	Polio	___	Tuberculosis	___
Hepatitis	___	Rheumatic Fever	___	Thyroid Disease	___		
Seizure	___	High Blood Pressure	___	Other	___		

SERIOUS MEDICAL ILLNESSES: Please list your past and present illnesses including date, where you were treated.

1. _____
2. _____
3. _____
4. _____

SERIOUS INJURIES: Please list any serious injuries including car accidents, broken bones, head trauma, etc along with the date.

1. _____
2. _____
3. _____

Do you wear seat belts? Yes _____ No _____

PAST OPERATIONS: Type & date. Hospital Surgeon

1. _____
2. _____
3. _____

Pregnancies _____ Miscarriages/Abortions _____ Any complications? _____

List your children with age & sex:

MEDICATIONS: Please list all medications and in what dosages you are taking them, including hormones, birth control pills and over-the-counter products.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 4. _____

Do you smoke cigarettes? _____	How many packs per day? _____
For how many years? _____	If you've quit, how long ago? _____
Do you drink alcohol? _____	What kind & how often? _____
How much? _____	How many years? _____

ALLERGIES: Please list medications to which you are allergic or ones you cannot tolerate for any reason.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 4. _____

Any other allergies? _____

Who in your family has had: (Father, Mother, Sister, Brother, Children, Grandparents, Aunt, Uncle)

1. Brain aneurysm _____
2. Cancer _____
3. Diabetes _____
4. High Blood Pressure _____
5. Heart Disease/Heart Attack _____
6. Mental Disease _____
7. Migraine Headaches _____
8. Seizures/Epilepsy _____
9. Stroke _____
10. Tuberculosis _____
11. Dialysis _____

12. Other _____

Please circle any of the following if it is a significant problem for you now or was in the past.

Headaches	Muscle Cramps	Suicidal Ideas
Nausea	Muscle Twitching/Jerking	Tenseness/Nervousness
Vomiting	Difficulty Walking	Loss of Appetite
Convulsions/Seizures	Unsteady Balance	Diff getting words out
Fainting	Incoordination	Hearing or seeing things
Loss of Vision	Trembling/Tremor/Shaking	Heat Intolerance
Droopy Eyelids	Diff controlling bladder	Palpitations/Skip beats
Loss of smell	Diff controlling bowel	Chest Pain
Loss of taste	Recent weight loss	Chronic Cough/Cough Blood
Ringing/Buzzing ears	Memory loss	Stomach Pain
Dizziness/Vertigo	Confusion	Jaundice
Slurred Speech	Depression	Swelling
Numbness/Tingling	Anxiety/Chronic Worry	Constipation
Insomnia	Weakness	