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Patient HISTORY Form

*****Please fill out the following form to the best of your knowledge******

Patient Name: ______________________ **Preferred Pharmacy/ies**: ______________________

Reason for Visit: ______________________ **Preferred Hospital**: ______________________

Physicians with whom we should share info.: ______________________

Allergies: ☐ None

Drug	Adverse Reaction

Other (i.e. Latex, IV dye): ______________________

Medications: ☐ None ***Please include all breathing medications, nebulizers, and insulin doses***

Name of Drug	Dosage	Times per Day	Reason for Taking

Vaccines: ☐ Influenza Date: ____________ ☐ Pneumonia Date: ____________

☐ BCG Date: ____________

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **Other**________________

Ethnicity and Race:

☐ White
☐ Asian
☐ Black / African American
☐ Hispanic or Latino

☐ Other

☐ American Indian / Alaska Native

☐ Native Hawaiian / other Pacific Islander

Medical History:

☐ COPD
☐ Thyroid Disorder
☐ Diabetes
☐ Pulmonary Fibrosis
☐ Asthma
☐ Coronary Artery Disease
☐ Congestive Heart Failure
☐ Kidney Failure
☐ Sleep Apnea
☐ Hypertension
☐ Stroke
☐ Blood Clots
☐ Pulmonary Hypertension
☐ Hepatitis
☐ Autoimmune Disease
☐ Seizures
☐ GERD/Heartburn
☐ Allergic rhinitis
☐ Atrial fibrillation
☐ Cancer: Type and Location: ______________________________

Treatment (e.g. chemo, radiation, surgery): ______________________________

Other: ______________________________

Surgical History:

☐ Appendectomy
☐ Gall Bladder
☐ Thyroidectomy
☐ Tonsillectomy
☐ Knee/Hip Replacement
☐ Hysterectomy
☐ Hernia Repair
☐ Sinus Surgery
☐ Heart Bypass

Other: ______________________________

Family History:

Relationship	Age(s), Living or at Death	Medical Conditions and/or Cause of Death
Father		
Mother		
Brother(s)		
Sister(s)		
Grandfather(s)		
Grandmother(s)		
Children		

Social History:

Marital Status: Married Single Widowed Divorced

Pets at home/work: Y or N If yes: Type/Breed: ______________________________

Tobacco Use: Y or N If yes: Type: Cigarette Cigar Pipe Chew/Snuff

Age of start: ______ Packs/day: ______ Quit date: ______________

If no: Any second-hand smoke exposure: ______________________________

Alcohol Use: Y or N If yes: Type(s) of alcohol: ______________ Drinks per week: ____________

Drug Use: Y or N If yes: Type and amount: ______________________________

Caffeine Use: Y or N If yes: Amount per day: ______________________________

Social History (cont):

Tuberculosis: Y or N   If no: Date of last PPD: ___________

If yes: Date of last chest x-ray: ___________   Date of treatment: ___________

Occupation(s): ____

Date of Retirement: _____________

Occupational/Environmental Exposures:

- ☐ Asbestos
- ☐ Hay/Farming
- ☐ Metal work/fumes
- ☐ Sandblasting/Painting
- ☐ Brick Laying
- ☐ Pigeon/Bird Exposure
- ☐ Coal
- ☐ Vicks Mentholatum
- ☐ Chemicals
  Type: _____________
- ☐ Hot tub/Jacuzzi

Health Care/Screening:

- ☐ Colonoscopy   Date: ___________
- ☐ Mammogram   Date: ___________
- ☐ Prostate (PSA)   Date: ___________
- ☐ Dexa Scan   Date: ___________
- ☐ GYN exam/Pap   Date: ___________
- ☐ Sleep Study   Date: ___________
- ☐ Echochardiogram/Stress Test
  Date: ___________
- ☐ Pulmonary Function Test   Date: ___________

Other:

Recent travel history: ____

Prior intubations: ____

Date of most recent hospitalization: ___________   If so, reason: ______________________

Recent antibiotics (Name(s) and duration): ______________________________

Recent steroid use (Date and duration): ______________________________

Review of Systems

General:

- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Fatigue
- ☐ Weight gain
- ☐ Night sweats
- ☐ Headaches
- ☐ Loss of appetite
- ☐ Insomnia/restless sleep

Head/Neck:

- ☐ Dry mouth
- ☐ Dry eyes
- ☐ Enlarged thyroid
- ☐ Ear ache
- ☐ Hearing loss
- ☐ Cataracts/Glaucoma
- ☐ Vision loss
- ☐ Post-nasal drip
- ☐ Sinusitis
- ☐ Nose bleeds
- ☐ Nasal polyps
- ☐ Tongue/mouth pain

Throat:

- ☐ Hoarseness
- ☐ Tongue pain
- ☐ Swelling
- ☐ Problems swallowing

Cardiovascular:

- ☐ Chest pain
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Chest pressure

Review of Systems Cont'd

Lungs:

- ☐ Cough
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Pleurisy
- ☐ Sputum production

Gastrointestinal:

☐ Nausea
☐ Vomiting
☐ Abdominal pain
☐ Red/maroon stool
☐ Blood in vomit
☐ Hemorrhoids
☐ Indigestion
☐ Heartburn/reflux
☐ Diarrhea

Genitourinary:

☐ Bloody urine
☐ Incontinence
☐ Pain with urination
☐ Decreased urine stream
☐ Kidney dysfunction
☐ Urination at night

Musculature:

☐ Weakness
☐ Difficulty standing
☐ Unsteady gait
☐ Muscle pain
☐ Shortness of breath when bending over
☐ Cramping
☐ Bone fracture

Skin:

☐ Rash
☐ Cyanosis (blue skin)
☐ Suspicious lesions
☐ Jaundice (yellow skin)
☐ Easy bruising

Neurologic:

☐ Loss of consciousness
☐ Seizures
☐ Dizziness
☐ Strokes
☐ Tremors/shaking
☐ Numbness/tingling
☐ Memory loss
☐ Use of walker, wheelchair, other assist device

Psychiatric:

☐ Anxiety
☐ Depression
☐ Irritability
☐ Agitation

Endocrine:

☐ Change in hair growth
☐ Excessive hunger / thirst
☐ Goiter (lump in neck)
☐ Heat / Cold intolerance
☐ Night sweats
☐ Day sweats

Lymphatic:

☐ Lower extremity edema
☐ Lymph node pain / enlargement
☐ Lymphedema

Allergy/Immunololgy:

☐ Seasonal allergies
☐ Sneezing
☐ Runny nose
☐ Itchy eyes

Signature of Patient: ______________________________ Date: ______________