# PATIENT HISTORY FORM

**INSTRUCTIONS: Please assist us in providing a thorough evaluation of your medical condition by completing this form prior to your initial visit.**

**NAME** _____ **TODAY'S DATE:** _____

**AGE** _____ **GENDER** _____

1. **REFERRAL INFORMATION:**
   **Who referred you to this office?**_____
   **Family Physician:** _____
2. **REASON FOR THIS EVALUATION (What specific questions do you want answered?):**
   _____
   _____
3. **DATE OF LAST COMPLETE PHYSICAL EXAMINATION WAS:**_____
4. **MEDICATIONS CURRENTLY USING:** **DOSE:** **DAILY FREQUENCY:**
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

*****PLEASE BRING IN SEPARATE LIST OF MEDICATIONS AND/OR PRESCRIPTION BOTTLES*****

5. **ALLERGIES OR DRUG INTOLERANCES:** **REACTION EXPERIENCED:**
   _____ _____
   _____ _____

*****PLEASE LIST ADDITIONAL ALLERGIES ON A SEPARATE PAGE*****

6. **SOCIAL HISTORY:**
   **Place of Birth** _____
   **Past or Present Occupation** _____
7. **SUBSTANCE USE:**
   **Caffeine Use (Coffee, Tea, Soda) – Please Circle One:** Everyday Occasional Never
   **How Much:**_____ **What Kind:**_____
   **Alcohol Use – Please Circle One:** Everyday Occasional Never
   **How Much:**_____ **What type of Alcohol:**_____
   **Have you ever used Tobacco? Please Circle One:** Current Former Never
   **If Current User: please circle all that apply to you:** Cigarette Pipe Cigar Dip/Chew
   **How much each day:**_____ **What age did you start:**_____
   **If Former User: Age Started:**_____ **Age Stopped:**_____ **How many packs/amount per day:**_____
8. **ACTIVITY HISTORY:**
   **What kind of exercise do you do?**
   _____
   _____
   **What is your main hindrance (if any) to exercising?**
   _____
   _____

# PAST MEDICAL HISTORY

| ✓ | MEDICAL PROBLEM | DATE OF ONSET | DETAILS/CIRCLE ONE |
|---|---|---|---|
| ___ | Abdominal Aneurysm | | |
| ___ | Anemia | | |
| ___ | Arthritis | | |
| ___ | Asthma | | |
| ___ | Atrial Fibrillation | | |
| ___ | Cancer (Please list type under Details) | | |
| ___ | Cardiomyopathy | | |
| ___ | Carotid Disease | | |
| ___ | Cellulitis | | |
| ___ | Cerebrovascular Accident (Stroke) | | |
| ___ | Chronic Dialysis | | Hemo or Peritoneal |
| ___ | Chronic Fatigue Syndrome | | |
| ___ | Chronic Obstructive Pulmonary Disease (COPD) | | |
| ___ | Coagulopathy (Bleeding Problems) | | |
| ___ | Colon Polyps | | |
| ___ | Congestive Heart Failure | | |
| ___ | Coronary Artery Disease | | |
| ___ | Deep Venous Thrombosis (DVT) | | |
| ___ | Dementia | | |
| ___ | Depression | | |
| ___ | Diabetes | | |
| ___ | Emphysema/COPD | | |
| ___ | Endocarditis | | |
| ___ | Gastrointestinal Bleed | | |
| ___ | Hepatitis | | |
| ___ | Hernia | | |
| ___ | HIV/AIDS | | |
| ___ | Hyperlipidemia (High Cholesterol) | | |
| ___ | Hypertension (High Blood Pressure) | | |
| ___ | Hyperthyroidism (High Thyroid) | | |
| ___ | Hypothyroidism (Low Thyroid) | | |
| ___ | Irritable Bowel | | |
| ___ | Kidney Stones (Chronic) | | |
| ___ | MRSA | | |
| ___ | Neuropathy | | |
| ___ | Palpitations | | |
| ___ | Peptic Ulcer Disease | | |
| ___ | Peripheral Vascular Disease (PVD) | | |
| ___ | Pneumonia | | |
| ___ | Pulmonary Embolus (Blood Clot to Lung) | | |
| ___ | Reflux/GERD | | |
| ___ | Renal Failure | | |
| ___ | Rheumatic Fever | | |
| ___ | Rheumatoid Arthritis | | |
| ___ | Seizure Disorder | | |
| ___ | Shortness of Breath | | |
| ___ | Sick Sinus Syndrome | | |
| ___ | Sleep Apnea | | |
| ___ | Supraventricular Tachycardia (SVT) | | |
| ___ | Syncope | | |
| ___ | Transient Ischemic Attack (TIA) | | |
| ___ | Tuberculosis | | |
| ___ | Ulcerative Colitis | | |
| ___ | Urinary Incontinence | | |
| ___ | Valvular Heart Disease | | |
| ___ | Ventricular Tachycardia | | |
| ___ | Wolf-Parkinson-White Syndrome | | |

# PAST SURGICAL HISTORY

| ✓ | SURGERY | DATE | DETAILS/CIRCLE ONE |
|---|---|---|---|
| ___ | Abdominal Aneurysm Repair | | ENDOGRAFT OPEN |
| ___ | Ablation (Please list type) | | |
| ___ | Aortic Valve Replacement | | MECHANICAL TISSUE |
| ___ | Appendectomy | | |
| ___ | AV Fistula for Hemodialysis | | |
| ___ | Automatic Implantable Cardioverter-Defibrillator (AICD) | | Manufacturer: Serial #: |
| ___ | Back Surgery | | |
| ___ | Bariatric Surgery (Weight Loss) | | |
| ___ | Breast Surgery | | RIGHT LEFT BOTH |
| ___ | Cardiac Catheterization | | |
| ___ | Cardioversion | | |
| ___ | Carotid Surgery | | RIGHT LEFT BOTH |
| ___ | Cataract Surgery | | RIGHT LEFT BOTH |
| ___ | Cesarean Section (C-Section) | | |
| ___ | Cholecystectomy (Gallbladder Removal) | | |
| ___ | Colon Surgery | | |
| ___ | Coronary Artery Bypass Graft (CABG) | | |
| ___ | Defibrillator Battery Change-out | | Manufacturer: Serial #: |
| ___ | Eye Surgery | | RIGHT LEFT BOTH |
| ___ | Foot Surgery | | RIGHT LEFT BOTH |
| ___ | Hemorrhoid Surgery | | INTERNAL EXTERNAL |
| ___ | Hernia Repair | | |
| ___ | Hip Surgery/Replacement | | RIGHT LEFT BOTH |
| ___ | Hysterectomy | | ABDOMINAL VAGINAL OVARIES |
| ___ | Knee Surgery/Replacement | | RIGHT LEFT BOTH |
| ___ | Lung Resection | | RIGHT LEFT BOTH |
| ___ | Mastectomy | | |
| ___ | Mitral Valve Repair/Replacement | | MECHANICAL TISSUE |
| ___ | Pacemaker | | Manufacturer: Serial #: |
| ___ | Pacemaker Battery Change-out | | |
| ___ | Prostate Surgery | | RIGHT LEFT BOTH |
| ___ | Shoulder Surgery | | RIGHT LEFT BOTH |
| ___ | Stent; Coronary | | |
| ___ | Stent; Vascular | | |
| ___ | Thyroid Surgery | | |
| ___ | Tonsillectomy | | |
| ___ | Vascular Surgery | | RIGHT LEFT BOTH |
| ___ | Vein Surgery | | RIGHT LEFT BOTH |
| ___ | Other: | | |
| ___ | Other: | | |

## FAMILY HISTORY

| ✓ | MEDICAL PROBLEM | AGE DECEASED | FAMILY MEMBER(S) |
|---|---|---|---|
| | Abdominal Aortic Aneurysm (AAA) | | |
| | Alzheimer's Disease | | |
| | Anxiety | | |
| | Cancer (Please list type) | | |
| | Carotid Artery Disease | | |
| | Congestive Heart Failure (CHF) | | |
| | Dementia | | |
| | Depression | | |
| | Diabetes | | |
| | Heart Attack | | |
| | Heart Disease | | |
| | Heart Surgery | | |
| | Hyperlipidemia (High Cholesterol) | | |
| | Hypertension (High Blood Pressure) | | |
| | Peripheral Vascular Disease (PVD) | | |
| | Stroke | | |
| | Thyroid Disease | | |
| | Valvular Heart Disease | | |
| | Other: | | |