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Patient History Form

Today's Date _____/_____/_____ Date of last physical exam _____/_____/_____

Last name _____First Name _____ Middle _____

DOB _____/_____/_____

What is the main reason for the visit today? (Please describe the problem in detail) _____

_____

_____

Past medical and social history

List all illnesses in your immediate family. (Example: diabetes, tuberculosis, cancer, heart disease, etc._____

_____

List any personal past illnesses and/or surgeries and when they occurred._____

_____

Do You Smoke? ____Yes ____ No How Much? _____ Do you Drink? ___ Yes ___ No How Much? _____

Please list all current medications: _____

_____

_____

_____

_____

_____

_____

Are you on a special diet? ___Yes ___ No If yes explain:_____

_____

Do you have allergies? ___ Yes ___ No Example: Penicillin, Sulfa, Any foods, etc. If yes explain:_____

_____

Describe your job:_____

For Children Patients Only

Is this on behalf of your child? ___ Yes ___ No Child's Name _____

Are immunizations current? ___ Yes ___ No

Has your child or does your child have the following? Please check all that apply ___ Asthma ___ Diabetes ___ Rheumatic Fever ___ Epilepsy ___ Other illnesses _____