

DO NOT WRITE IN THIS BOX

NURSE DATA: BP: _____ Pulse: _____ Wt.: _____ Blood Sugar: _____

PATIENT HISTORY FORM

Name: _____ Date: _____

Age: _____ Height: _____

Reason for Visit: _____

Medication (name, dosage and how often taken): _____

Vitamins / Supplements: _____

Allergies to Medications: _____

PAST MEDICAL HISTORY - Check any that you have ever had

Thyroid: Hypothyroid / Underactive Hyperthyroid / Overactive
 Thyroid Cancer Thyroid Nodule
 Thyroid Surgery

Diabetes: Age when diagnosed _____ Type 1 Type 2
 Retinopathy Laser needed When was last eye exam _____
 Eye Doctor's Name: _____
 Gestational Diabetes

Heart: Heart Attack Heart Failure Atrial Fibrillation Elevated Cholesterol Angioplasty / Stent Pacemaker Stroke High Blood Pressure

Cancer of: Lung Colon Prostate Breast Other: _____

Lung: Asthma COPD / Emphysema Sleep Apnea Other: _____

Bone: Osteoporosis / Osteopenia Hip Fracture Spine Fracture Wrist Fracture Other: _____

Liver / Stomach: Chronic Hepatitis Celiac Disease Gallstones GERD / Reflux Other: _____

Kidney Disease: Frequent Infections Impaired Function Dialysis Kidney Stones Other: _____

Brain or Nervous Disorders: Seizures Neuropathy Stroke Other: _____

Other Major Medical Problems: _____

Year of Last Flu Shot: _____ Pneumonia Vaccination? Yes _____ No _____

Surgeries: No surgeries

<input type="checkbox"/> Bariatric	When: _____	<input type="checkbox"/> Leg Bypass	When: _____	<input type="checkbox"/> Hip Replacement	When: _____
<input type="checkbox"/> Heart Bypass	When: _____	<input type="checkbox"/> Angioplasty / Stent	When: _____	<input type="checkbox"/> Hysterectomy	When: _____
<input type="checkbox"/> Carotid Surgery	When: _____	<input type="checkbox"/> Gallbladder	When: _____	<input type="checkbox"/> Tubal Ligation	When: _____
<input type="checkbox"/> Any Other Surgery (Describe)	_____	When: _____		<input type="checkbox"/> Thyroid	When: _____

Name: _____

FAMILY HISTORY (parents, grandparents, siblings, children)

High Blood Pressure: _____

Heart Attack: _____

Stroke: _____

Diabetes: Adult Onset/Type 2: _____ Juvenile Onset/Type 1: _____

Thyroid: Hypothyroid / Underactive: _____ Hyperthyroid / Overactive: _____

Thyroid Nodules: _____ Goiter: _____

Cancer / Type: _____

Other Diseases that run in your family: _____

SOCIAL HISTORY

Occupation: _____

Marital Status: _____ # of children: _____ (# of sons _____ # of daughters _____)

Smoking Current Cigarette Smoker - Everyday Some Days
 Non-cigarette Smoker - Never smoked Former Smoker (Quit Date _____)

Alcohol Yes - Daily Weekly Socially (Amount _____) I Don't Drink Alcohol

Exercise Yes (Frequency per week _____ / Type of Exercise _____) No

Special Diet Yes No Restrictions: _____

REVIEW OF SYSTEMS (Circle if you **CURRENTLY** have problems with)

General: Weight Loss (____ lbs. over ____ months/years) / Weight Gain (____ lbs. over ____ months/years) / Fatigue / Insomnia

HENT: Persistent Hoarseness / Voice weakness / Loud Snoring / Sleep Apnea

HEME: Easy Bruising / Anemia

Endocrine: Excessive Thirst / Excessive Urination / Urination at Night - How many times? _____ / Sensitive to cold temperature / Sensitive to hot temperature / Breast Growth (men) / Breast Discharge / Poor Libido

Gynecological: Irregular Periods / Heavy Periods / Infertility / Post-menopausal

Urinary: Erectile Dysfunction / Poor Stream / Incomplete Urination / Frequent Urination / Pain with Urination

Heart: Chest Pain or Pressure / Leg Swelling / Shortness of Breath / Palpitations / Awakening Short of Breath at Night

Lungs: Wheezing / Cough / Shortness of Breath

Gastrointestinal: Constipation / Diarrhea / Heart Burn / Stomach Pain / Vomiting / Nausea

Skin: Excessive Acne / Excessive Hair Growth (women) / Hair Loss (women) / Vitiligo

Neurologic: Numbness of _____ / Frequent Headaches / Migraines / Tingling or Burning Pain in Feet / Tingling or Burning Pain in Hands

Musculoskeletal: Arthritis / Back Pain / Joint Swelling or Stiffness / Fractures - of What? _____

Eye: Double Vision / Glaucoma / Loss of Vision / Decreased Vision / Blurred Vision / Bulging Eyes

Psychiatric: Depression / Anxiety

under treatment self controlled not treated / not controlled