DO NOT WRITE IN THIS BOX

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

PATIENT HISTORY FORM

Name: ______________________________ Date: ______________

Age: ______________ Height: ______________

Reason for Visit: ______________________________

Please complete medication sheet (Page #3)

Vitamins / Supplements: ______________________________

____

Allergies or Adverse Reactions to Med.: ______________________________

____

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: ______________
- ❑ Neuropathy
- ❑ Increased Urine Protein
- ❑ 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:
- ❑ Inflammatory Bowel
- ❑ 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: ❑ COVID Infection ______________ COVID Vaccination? ❑ Yes ❑ No

____

Surgeries: ❑ No surgeries

- ❑ Bariatric When: ________
- ❑ Heart Bypass When: ________
- ❑ Carotid Surgery When: ________
- ❑ Leg Bypass When: ________
- ❑ Angioplasty / Stent When: ________
- ❑ Gallbladder When: ________
- ❑ Any Other Surgery (Describe) ______________ When: ________

____

- ❑ Hip Replacement When: ________
- ❑ Hysterectomy When: ________
- ❑ Tubal Ligation When: ________
- ❑ Thyroid When: ________
- ❑ Transplant of ______________

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 / CPAP Use

HEME: Easy Bruising / Anemia

Endocrine: Excessive Thirst / Excessive Urination / Urination at Night - How many times? ________ /
Sensitive to coldtemperature / 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 / Kidney Stones

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

Medications for:____________________________Date of Birth:________

Include your over the counter medicines and any diabetes supplies. For insulin, include whether pen or vial and concentration (U-100, U-200, U-300, U-500)

Medication (For insulin, pen or vial)	Dose	Frequency	Times Taken				Check if as needed