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 ❑ Neuropathy
  - ❑ Laser needed ❑ Increased Urine Protein
  - ❑ 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

- ❑ Bariatric When: _____
- ❑ Heart Bypass When: _____
- ❑ Carotid Surgery When: _____
- ❑ Any Other Surgery (Describe) _____ When: _____
- ❑ Leg Bypass When: _____
- ❑ Angioplasty / Stent When: _____
- ❑ Gallbladder When: _____
- ❑ Hip Replacement When: _____
- ❑ Hysterectomy When: _____
- ❑ Tubal Ligation When: _____
- ❑ 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

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