McMillan & Ustick Medical Centers-Family Practice

PATIENT HISTORY FORM

Patient Name_______________________________ DOB___________Occupation____________________
Employment Status: Homemaker Retired Disabled Part-Time Full-Time
Single_____ Married (how long) _______Divorced (how long) ________Widowed (how long) ________
Domestic Partnership (how long) ______Children (how many) _________ Ages of Children?_________________
Allergies to Medications/other____
Do you have an Advanced Directive (Living Will) completed? Y N
Current Symptom(s)/Problems which you are most concerned about today?____

SOCIAL HISTORY

Do you drink caffeinated beverages? Y N Cups/Glasses/Cans per day? ____________
Do you drink Alcohol? Y N Alcohol type_____________ How much per week? _____________
Do you use Tobacco products? NO Cigarettes Cigars Chew Tobacco Quit
If yes, how many years have you used tobacco?_________ How much per day? _______________
Do you exercise regularly? Y N Type_____________________ Amount weekly_____________
Average number of hours of sleep you get nightly_____________ Do you feel it is enough? Y N
Do you wake up feeling rested? Y N
Do you use any drug for reasons that are not medical? Y N List:____________________________

FAMILY HISTORY

Illness/Condition	Grandparents	Father	Mother	Brother	Sister	Son	Daughter	Other	Other
Cancer-Type?									
Heart Disease									
Diabetes									
High Blood Pressure									
Liver Disease									
High Cholesterol									
Lung Disease									
Depression									
Genetic Disorder									
Alcohol/Drug Abuse									
Other									
Living?									

Serious Injury/Surgery History/Hospitalizations

Injury or Surgery	When?	Reason?

SYSTEM REVIEW (Circle Applicable Symptoms)

GENERAL

Weight loss/gain of 10+ lbs. in last 6 months
Poor Sleep
Energy Changes
Fever
Headache
Depression/Anxiety
Last Flu Shot?_________
Other___________________________

NEUROLOGIC

Dizziness/Weakness
History of Stroke/Head Injury
Blackouts/ Loss of Consciousness/Seizures
Other___________________________

ENDOCRINE

History of Diabetes
History of Thyroid Disease
Change in tolerance to hot/cold climate
Excessive Thirst
Other___________________________

EYES, EARS, NOSE, THROAT

Blurred Vision
Other Vision Changes
History of Cataracts/Glaucoma
Wear Glasses? Y N Contacts? Y N
Date of Last Eye Exam_____________
Loss of Hearing
Ringing in Ears
Date of Last Hearing Test___________
Date of Last Dental Exam___________
Sinus Problems
Hoarseness
Other___________________________

CIRCULATION/HEART

History of Angina/Chest Pain/Heart Attack
History of High Blood Pressure
History of Irregular heartbeat/Murmur
History of Poor Circulation/Blood Clots
Blood/Blood Products received
Other___________________________

PULMONARY/LUNGS

Shortness of Breath
Persistent Cough
Snoring/Apnea
Coughing up Blood/Sputum
Asthma/Wheezing/ COPD/Emphysema
If you are over 50, have you had a Pneumonia Shot? Y N
Other___________________________

PERSONAL HISTORY (Describe any circled answers)

GASTROINTESTINAL

Poor appetite
Abdominal Pain
Indigestion/Heartburn/Acid Reflux
Trouble swallowing
Diarrhea/ Constipation
Hernias
Change in Bowel Habits
Nausea/Vomiting/Vomiting Blood
Rectal Bleeding/Blood in Stools/Hemorrhoids
History of Liver Disease/Abnormal Liver Test
If over 50, have you had a Colonoscopy? Y N When?____
Other___________________________

GENITOURINARY

Urinary Frequency/ Blood in Urine/Urinary Tract Infections
History of Kidney Disease
Abnormal Kidney Test
Other___________________________

WOMEN ONLY

Abnormal Pap Smear Y N Year of last Pap?_______
Bleeding between Periods/ Abnormal Menstrual Cycle
Pregnancies?________ Deliveries?__________
Vaginal itching/Discharge
Date of Last Mammogram_______________
Breast Pain/Lumps/Discharge
Have you ever had a Bone Density Test? Y N
Other___________________________

MEN ONLY

PSA Test
Abnormal PSA
Changes in Urinary Stream/Dribbling/Hesitancy
Testicular Pain/Masses
Other___________________________

MUSCLE/JOINT/BONE

Swelling of Ankles/Legs
Pain/Weakness/Numbness/Tingling in:
- Arms or Hands
- Back or Hips
- Legs or Feet
- Neck or Shoulders

Other___________________________

SKIN

Itching/Rashes
Excessive Bruising
Change in Moles/Hair/Nails
Last Tetanus shot?_______
Other__________________________