Annual Patient History Form

Today's Date:____________

Name:____________________ **Age**:____ **Date of Birth**:____________

First Day of Last Menstrual Cycle:________________ Hysterectomy (circle one): Yes or No

Describe any Problems you'd like to discuss today:____

____

Number of Pregnancies_______ **Number of Miscarriages or Terminations**____________

Number of C-Section Deliveries_________ **Infertility Treatments**_____________________

Previous Surgeries/Hospitalizations/Serious Injuries: Date:

____ ________________

____ ________________

____ ________________

List of Medications: (If you have a list, please give to the check- in desk to make a copy)

1)__________________ 3)__________________ 5)_________________ 7)________________ 9)__________________

2)__________________ 4)__________________ 6)_________________ 8)________________ 10)__________________

Social History: (Circle one)

Marital Status: Married Single Separated Divorced Widowed

Use of Alcohol: Never Rarely Moderate Daily—Drinks per day_____________

Tobacco Use: Never Previously but Quit Current Packs per Day____________

Drug Use: Never Type/Frequency____________________

Have you ever had the following: (circle all that apply)

DiabetesHypertension Cancer: Type___________ Stroke Heart Problems Convulsions

Arthritis/Gout Bleeding Tendency Acute Infections Venereal Disease Hereditary Defects

Family Medical History Age (current) Disease or Illness If Deceased, Cause of Death

Father ____

Mother ____

Siblings ____

Children ____

Spouse ____

In the Past 3 months, have you had any of the following:

CONSTITUTIONAL

Recent weight change..................................	No	Yes
Fever...	No	Yes
Fatigue...	No	Yes
Headaches...	No	Yes

EYES

Blurred or double vision..............................	No	Yes

ENT

Hearing loss..	No	Yes
Earaches or drainage....................................	No	Yes
Sinus problems...	No	Yes
Nose bleeds..	No	Yes
Mouth sores..	No	Yes
Sore throat or voice change..........................	No	Yes
Swollen glands in neck................................	No	Yes

CARDIOVASCULAR

Heart trouble..	No	Yes
Chest pains...	No	Yes
Sudden heart beat changes...........................	No	Yes
Swelling of feet, ankles or hands..................	No	Yes

RESPIRATORY

Frequent coughing..	No	Yes
Spitting up blood..	No	Yes
Shortness of breath.......................................	No	Yes
Asthma or wheezing.....................................	No	Yes

GASTRONITESTINAL

Loss of appetite..	No	Yes
Change in bowel movements........................	No	Yes
Nausea or vomiting......................................	No	Yes
Frequent diarrhea...	No	Yes
Blood in stool...	No	Yes
Stomach pain..	No	Yes

GENITOURINARY

Frequent urination...	No	Yes
Burning or painful urination.........................	No	Yes
Blood in urine...	No	Yes
Change or force of strain when urinating......	No	Yes
Incontinence or dribbling.............................	No	Yes
Kidney stones...	No	Yes
Sexual difficulty...	No	Yes
Pain with periods..	No	Yes
Irregular periods...	No	Yes
Vaginal discharge...	No	Yes

pregnancies _______ # miscarriages ______

Date of last pap smear ____________________

Findings of last pap smear Normal Abnormal

MUSCULOSKELETAL

Joint pain...	No	Yes
Joint stiffness or swelling...............................	No	Yes
Weakness of muscles or joints.......................	No	Yes
Muscle pain or cramps..................................	No	Yes
Back pain..	No	Yes
Cold extremities..	No	Yes
Difficulty in walking.....................................	No	Yes

SKIN

Rash or itching..	No	Yes
Change in skin color.....................................	No	Yes
Change in hair or nails..................................	No	Yes
Varicose veins...	No	Yes
Breast pain...	No	Yes
Breast lump...	No	Yes
Breast discharge..	No	Yes

NEUROLOGICAL

Frequent or recurring headaches.....................	No	Yes
Light headed or dizzy....................................	No	Yes
Convulsions or seizures.................................	No	Yes
Numbness or tingling sensations....................	No	Yes
Tremors...	No	Yes
Paralysis..	No	Yes
Head injury...	No	Yes

PSYCHIATRIC

Memory loss or confusion..............................	No	Yes
Nervousness...	No	Yes
Depression...	No	Yes
Sleep problems...	No	Yes

ENDOCRINE

Thyroid disease..	No	Yes
Diabetes..	No	Yes
Excessive thirst or urination...........................	No	Yes
Heat or cold intolerance.................................	No	Yes
Dry skin...	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts....................................	No	Yes
Easily bruise or bleed.....................................	No	Yes
Anemia...	No	Yes
Phlebitis..	No	Yes
Past transfusion...	No	Yes
Enlarged glands..	No	Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reactions to:

Penicillin or other antibiotics................	No	Yes
Morphine, Demerol or other narcotics...	No	Yes
Novocaine or other anesthetics.............	No	Yes
Aspirin or other pain remedies.............	No	Yes
Tetanus antitoxin or other serums.........	No	Yes
Iodine, methiolate or other antiseptic....	No	Yes

Other drugs/medications__________________________________

Known food allergies____________________________________