



ESTABLISHED PATIENT HISTORY FORM

Date: _____

Name: _____

Age: _____

DOB: _____

Please complete the following to the best of your ability.

What is your concern to be addressed today? _____

PLEASE CHECK HERE IF THERE HAVE BEEN NO CHANGES IN YOUR HISTORY (including medications and allergies) SINCE THE LAST VISIT. Proceed to the back of this form and complete step 8, the REVIEW OF SYSTEMS.

PAST MEDICAL/SURGICAL HISTORY:

1. Please check the box to indicate if you have/had any of the following and provide details in the space provided:

- checkbox diabetes, high blood pressure, heart disease, bleeding disorder, lung problems, liver problems, kidney problems, neurological problems, cancer, anxiety/depression, allergy problems, other medical problems

2. Please list any surgeries you have ever had.

- bulleted list lines for surgery details

3. Have you ever had problems with anesthesia? YES NO If yes, please explain.

4. Please list ALL MEDICATIONS (including herbals, supplements) with dose and times per day.

Table with 6 columns: MEDICATION, DOSE, FREQUENCY, MEDICATION, DOSE, FREQUENCY

5. FAMILY HISTORY

Please check the box to indicate if your family members have had any of the following and provide which relatives in the space provided:

- checkbox diabetes, anesthesia problems, heart disease, bleeding disorder, cancer, other medical problems

6. ALLERGIES: Please list any allergies to medications.

- lines for listing allergies

PLEASE TURN THE FORM OVER AND COMPLETE THE BACK.

7. SOCIAL HISTORY

I am:

- working
- retired
- disabled
- occupation (or previous)

Marital Status:

- single
- married
- divorced
- separated
- widowed

Education:

- grade _____
- technical/trade school
- college degree
- post-graduate degree

Do you have children? YES NO How many? _____

Do you smoke?

- Yes, current ___ packs per day
- No, but in the past ___ packs per day
- No, never

Do you drink alcohol?

- Yes, current ___ drinks per week
- No, but in the past ___ drinks per week
- No, never

Do you currently use recreational or illicit drugs? YES NO If yes, what? _____

How many caffeinated beverages do you drink daily? _____ How many 8oz glasses of water do you drink daily? _____

8. REVIEW OF SYSTEMS:

Please check the box to indicate if you currently have any of the following:

General/Constitutional

- fever
- chills
- fatigue
- weight gain
- weight loss

HEENT

- vision changes
- wear glasses/contacts
- dry eyes
- hearing loss
- ringing in your ears
- sore throat
- voice changes
- swallowing problems
- nosebleeds
- nasal congestion
- nasal drainage
- seasonal allergies
- ear pain
- ear pressure
- ear drainage
- vertigo (spinning)

Cardiovascular

- irregular heart beat
- chest pain
- shortness of breath with exertion

Respiratory

- shortness of breath
- chronic cough
- cough up blood

Gastrointestinal

- abdominal pain
- nausea
- vomiting
- diarrhea
- constipation
- heartburn

Genitourinary

- trouble urinating
- blood in the urine

Musculoskeletal

- joint pain
- muscle pain
- back pain

Neurological

- dizziness
- fainting spells
- focal weakness
- chronic headaches
- tremor

Psychiatric

- depression
- anxiety
- schizophrenia

- bipolar

Lymph/Heme

- bleeding disorders
- history of blood cancers

Endocrine

- excessive thirst
- excessive urination
- feel warmer than others
- feel cooler than others

Skin

- rash
- hives
- skin lesions

Sleep

- drowsy during the day
- snore loudly
- pause/stop breathing at night
- sudden episodes of sleep during day
- morning headaches
- trouble falling asleep
- trouble staying asleep
- had a sleep study
- use CPAP

Reviewed by: _____

Date: _____