



# Patient History Form for Use with EMR

*This is a confidential record and will be kept in your electronic patient chart*

*Information contained here will not be released to anyone without your authorization to do so.*

TODAY'S DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_

Reason for seeing the physician on the first visit: \_\_\_\_\_

Have you been exposed to or currently have TB (tuberculosis)?      Y      N

Have you received the Pneumonia Vaccine in the last 9 years?      Y      N      Date \_\_\_\_\_

### ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:

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### LIST CURRENT MEDICATIONS (include over the counter items such as aspirin)

<u>MEDICATION/DOSAGE</u>	<u>MEDICATION/DOSAGE</u>
1. _____	7. _____
2. _____	8. _____
3. _____	9. _____
4. _____	10. _____
5. _____	11. _____
6. _____	12. _____

### OVER-THE-COUNTER SUPPLEMENT MEDICATIONS (if nothing marked then NONE APPLY)

Echinacea	Metabolife	Garlic	Ginkgo	Ginseng
Kava	St. Johns Wort	Valerian	Fish Oil	Vitamin E
Other _____	Other _____			

Are you required to take antibiotics with dental work?      N      Y

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ DOB \_\_\_\_\_

**PAST SURGICAL HISTORY – Check previous surgeries & provide date** *(if nothing marked then NONE APPLY)*

<input type="checkbox"/> Bladder augmentation _____	<input type="checkbox"/> Adrenalectomy _____
<input type="checkbox"/> Bladder suspension _____	<input type="checkbox"/> Appendectomy _____
<input type="checkbox"/> Cystectomy _____	<input type="checkbox"/> Back surgery _____
<input type="checkbox"/> Cystoscopy _____	<input type="checkbox"/> Breast biopsy _____
<input type="checkbox"/> Green light PVP _____	<input type="checkbox"/> CABG _____
<input type="checkbox"/> Hydrocele repair _____	<input type="checkbox"/> Cesarean section _____
<input type="checkbox"/> Kidney Stone Removal _____	<input type="checkbox"/> Cholecystectomy _____
<input type="checkbox"/> Laparoscopy _____	<input type="checkbox"/> Colon surgery _____
List type of Laparoscopy _____	<input type="checkbox"/> Colonoscopy _____
<input type="checkbox"/> Lithotripsy _____	<input type="checkbox"/> Coronary Stent _____
<input type="checkbox"/> Nephrectomy _____	<input type="checkbox"/> Gastric bypass _____
<input type="checkbox"/> Pacemaker _____	<input type="checkbox"/> Heart Valve Replacement _____
<input type="checkbox"/> Percutaneous nephrolithotomy _____	<input type="checkbox"/> Hernia repair _____
<input type="checkbox"/> Pubovaginal sling _____	<input type="checkbox"/> Hip replacement _____
<input type="checkbox"/> Tubal ligation _____	<input type="checkbox"/> Hysterectomy _____
<input type="checkbox"/> Ureteroscopy-stent _____	<input type="checkbox"/> Knee replacement _____
<input type="checkbox"/> Vasectomy _____	<input type="checkbox"/> Mastectomy _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

**PAST MEDICAL HISTORY – Check any previous past medical problems** *(if nothing marked then NONE APPLY)*

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes 1 OR 2 (circle one)	<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Angina (Chest Pain)	<input type="checkbox"/> Diverticular disease	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> GERD (Gastric Reflux)	<input type="checkbox"/> MI (Heart Attack)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> BPH	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Peptic Ulcer Disease
List type of cancer _____	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> CVA (Stroke)	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Disease
<input type="checkbox"/> Chronic UTIs	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Dialysis
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Inflammatory bowel disease	( <input type="checkbox"/> Hemo <input type="checkbox"/> Peritoneal)
<input type="checkbox"/> COPD	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Lupus	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Depression		<input type="checkbox"/> Urolithiasis (Kidney Stones)
Other _____	Other _____	



LAST NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_

DOB \_\_\_\_\_

**REVIEW OF SYSTEMS** – Please circle any symptoms you are currently experiencing.

<b>Constitutional:</b>	Fever	Chills	Weight Loss	
<b>Eyes:</b>	Blurry Vision	Cataracts	Glaucoma	
<b>Ears, Nose, Mouth, Throat:</b>	Hearing Loss	Nasal Stuffiness	Sore Throat	
<b>Cardiovascular:</b>	Chest Pains	Swollen Ankles	Irregular Heartbeat	
<b>Respiratory:</b>	Shortness Of Breath	Wheezing	Chronic Cough	Known TB Exposure
<b>Gastrointestinal:</b>	Abdominal Pain	Nausea/Vomiting	Change In Bowels	
<b>Musculoskeletal:</b>	Chronic Back Pain	Chronic Neck Pain	Sore Muscles	
<b>Integumentary/Skin:</b>	Rash	Persistent Itching	Skin Cancer History	
<b>Neurological:</b>	Numbness	Tingling	Dizziness	
<b>Hematologic/Lymphatic:</b>	Swollen Glands	Abnormal Bleeding	Transfusion History	
<b>Psychiatric:</b>	Anxiety	Depression		

**Recent Colonoscopy:      Date Of Procedure:**

**Recent Pneumonia Vaccine:      Date Of Injection:**

**APPROXIMATE HEIGHT:** \_\_\_\_\_

**WEIGHT:** \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_