PRIVATE M.D. PATIENT HISTORY FORM

Patient's Name: ______________________________________
Today's Date: ______________________________
Social Security Number: _______________________________
Date of Birth: _______________________________

Past Medical History
Previous Physician's name: _____________________________
Date of last exam: ___________________________
Have you ever been hospitalized? □Yes □No If yes, what for?
____
Have you ever been tested for hepatitis A, B or C? □Yes □No
Which hepatitis virus?___________________
Have you been vaccinated for hepatitis B? □Yes □No If yes, date vaccine series completed _____________
Have you been vaccinated for hepatitis A? □Yes □No If yes, date vaccine series completed _____________
Last Tuberculosis (TB) Screening? ________________________
Result of TB screening: □Positive □Negative
If positive TB screen, date of last chest x-ray: ________________
Result of chest x-ray: □Positive □Negative
Have you had a sexually transmitted disease? □Yes □No
Diagnosis: _________________________________

Which of the following conditions are you currently being treated or have been treated for in the past (please circle)

Visual problems/Glasses
Neurologic problems
Jaundice
Anemia
Anorexia/Bulimia
Tuberculosis
Diabetes
Thyroid/Goiter
Stomach problems/Ulcers
CVA/Stroke
Syphillis/Chlamydia
Gallbladder/Liver Disease
Headaches/Dizziness
Psychological problems
Cancer
Hypertension
Drug/Alcohol abuse
Blood Clots
Heart problems
Gonorrhea/Herpes/Warts
Kidney problems
Hyperlipidemia

Urinary tract infections	Hemorrhoids/Rectal
Rheumatic fever	Back problems
Bleeding	Seizures
Asthma/Allergies	Pelvic/Vaginal infections
Breast disease	Frequent colds/sore throats
Pneumonia/Bronchitis	Skin Problems
Ear infections	Arthritis

Surgeries and Hospitalization (include dates):___________________________
____
____

Allergies (medications and food):_____________________________________
____
____
Other:____

Current Medications:____

IMMUNIZATIONS: (include dates) Hepatitis B____________
Influenza_____________ TB test/results___________________
DPT/Td (tetanus)____________ OPV (polio)___________ MMR (measles, mumps, rubella)_____________ Varicella_____________
Other_________________

FAMILY HISTORY (circle and include parents, grandparents, brothers, sisters who have/had)

Heart disease	Cancer
Kidney disease	High blood pressure
Diabetes	Tuberculosis
CVA/Stroke	Arthritis
Anemia	Thyroid/Goiter
Epilepsy/Seizures	Asthma/Allergies
Birth defects	D.E.S. (mother)
Liver Disease	Mental health problems
Alzheimer’s disease	Alcoholism

Additional Information:____
____

LIFESTYLE HISTORY (circle items of interest):

I am interested in making the following changes or need counseling in:
1. Smoking cessation
2. Weight control
3. Decrease alcohol consumption
4. Exercise
5. Decrease use of drugs/stimulants
6. Seat belt usage
7. Nutrition
8. Stress management

LIFESTYLE HABITS

Exercise:	Activity_______________	amount_________	
Alcohol intake/week:	Activity_______________	amount_________	
Tobacco use:	Activity_______________	amount_________	
Nutrition:	Caffeine (amt/day)______________________		
	meals/day_____________	vitamins________	
Seatbelt use: (circle)	always sometimes	never	

Manage stress/stressors in life appropriately: (circle)
always sometimes never

EDUCATION:
Highest level completed:____

OCCUPATIONAL HISTORY
Present job:
What type of work do you do?____
How long have you had this job?_______________________________________

Are you exposed to any of the following on your present job?
Chemicals_____________ Vapors/Gases_______________ Dusts___________
Metals___________ Extreme heat or cold_______________ Loud noise______
Vibration______________ Radiation________ Infectious agents____________
Stress____________

Do you feel you have any health problems related to your work?

Yes_____________ No________ If yes, please describe:_________________
____

List any injuries or illnesses during previous work years, include dates:_____
____
____

Do you have any hobbies that expose you to chemicals, metals, or other substances? Yes_______ No_____________ If yes, please describe:_______
____

Do you live near any sources of pollution? (Dump sites, etc.) Yes__________
_____ No_____________

Additional information:____
____
____
____

ALL MALES STOP HERE

GYNECOLOGICAL HISTORY
(FEMALES fill in information or appropriate spaces):

Menses (age of onset):________________________

History of any of the following:

Cycles: Regular__________ Irregular_________
Ovarian cysts_____________________________
Duration: Number of days___________________
Uterine fibroid_____________________________
Scant _____Moderate________ Heavy__________
Premenstrual syndrome______________________
Cessation of menses (age):___________________
Sexual problems___________________________
Dysmenorrhea (cramping)?___________________
Last pap smear/result:_______________________

Vaginal discharge/itching?____________________
Self breast exams?___________________________
Bleeding between periods?____________________
Douching? ___________Type?___________How often?_________________

Present birth control method (type and number of years used):_____________
____
Previous methods:____

Additional information:____
____

OBSTETRICAL HISTORY (FEMALES fill in information or appropriate space):

Number of pregnancies _______Number of deliveries_________
Abortions______________Vaginal deliveries__________________
Caesarean section_______Date of last delivery________________

Complications during pregnancy with:
Blood pressure_________ Blood sugar___________
Weight gain______ Anemia_________ Other_____

Additional Information:____
____
____
____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.
Patient/Legal Guardian Signature
____
Date _________________