Patient History Form

This is a confidential record and will be kept in your doctor's office.
Information contained here will not be released to anyone without your authorization.

Allergies	Type of Reaction

Medical History	Year

Social History

Smoking	Yes No	
Alcohol	Yes No	
Street Drugs	Yes No	
Caffeine	Yes No	
Tattoos/Piercings	Yes No	
Exercise	Yes No	
Special Diet	Yes No	
Living Will	Yes No	

GR ____ PARA ____AB _____ ☐ MENARCHE _____ ☐ MENOPAUSE _____

Marital Status: ☐ SINGLE ☐ Married ☐ WIDOWED

☐ Deaf ☐ HOH ☐ Bllind ☐ VISION IMPAIRED ☐ Aids for Mobility _____

Spouse's Name: _____

Occupation: _____

Surgical History	Year

Immunizations

	Dates					
Influenza						
Diphtheria/Tetanus						
Pneumonia						
PPD						

Family History

Relationship	Problems
Mother	
Father	
Maternal GP	
Paternal GP	
Siblings	
Children	

Health Maintenance

	Date	Results	Date	Results	Date	Results	Date	Results	Date	Results
Annual Exam										
PAP										
Mammogram										
Bone Density										
EKG										
Chest X-ray										
Stress Test										
Echo										
Dopplers										
PSA										
FOBT										
Colonscope/BE										
Eye Exam										
Dental Exam										

Comments/Notes

PT NAME _____ DOB _____ Provider: _____