PATIENT HISTORY FORM

Name: _____ **Date:** _____

Mailing Address: _____
Street city state zip

Social Security Number: Phone: (H) (W)

DOB:	Height:	Weight:	HR:	BP:
Gender:	Pregnancy Status:			

Allergies: _____ **Reactions:** _____

PRESCRIPTION MEDICATION HISTORY						
Name/Strength	Directions	Start Date	Stop Date	Physician	Purpose	Effectiveness

NONPRESCRIPTION USE: Check conditions for which you have used a nonprescription medication.

- ☐ headache
- ☐ eye/ear problems
- ☐ cold/flu
- ☐ allergies
- ☐ sinus
- ☐ cough
- ☐ sleeplessness
- ☐ drowsiness
- ☐ weight loss
- ☐ diarrhea
- ☐ hemorrhoids
- ☐ muscle/joint pain
- ☐ rash/itching/dry skin
- ☐ heartburn/GI upset/gas
- ☐ vitamins
- ☐ herbal products
- ☐ organic products
- ☐ other: _____

NONPRESCRIPTION MEDICATION HISTORY				
Name/Strength	Directions	Purpose	How Often	Effectiveness

MEDICAL PROBLEMS: Have you experienced, or do you have: (check Y or N)

known kidney problems?	☐ Y ☐ N	sores on legs or feet?	☐ Y ☐ N
frequent urinary infections?	☐ Y ☐ N	known blood clot problems?	☐ Y ☐ N
difficulty with urination?	☐ Y ☐ N	leg pain or swelling?	☐ Y ☐ N
frequent urination at night?	☐ Y ☐ N	unusual bleeding or bruising?	☐ Y ☐ N
known liver problems/hepatitis?	☐ Y ☐ N	anemia?	☐ Y ☐ N
trouble eating certain foods?	☐ Y ☐ N	thyroid problems?	☐ Y ☐ N
nausea or vomiting?	☐ Y ☐ N	known hormone problems?	☐ Y ☐ N
constipation or diarrhea?	☐ Y ☐ N	arthritis or joint problems?	☐ Y ☐ N
bloody or black bowel movements?	☐ Y ☐ N	muscle cramps or weakness?	☐ Y ☐ N
abdominal pain or cramps?	☐ Y ☐ N	memory problems?	☐ Y ☐ N
frequent heartburn/indigestion?	☐ Y ☐ N	dizziness?	☐ Y ☐ N
stomach ulcers in the past?	☐ Y ☐ N	hearing or visual problems?	☐ Y ☐ N
shortness of breath?	☐ Y ☐ N	frequent headaches?	☐ Y ☐ N
coughing up phlegm or blood?	☐ Y ☐ N	rash or hives?	☐ Y ☐ N
chest pain or tightness?	☐ Y ☐ N	change in appetite/taste?	☐ Y ☐ N
fainting spells or passing out?	☐ Y ☐ N	walking/balance problems?	☐ Y ☐ N
thumping or racing heart?	☐ Y ☐ N	other problems?	☐ Y ☐ N

MEDICAL HISTORY: Have you or any blood relative had: (check all that apply)

	self	relative		self	relative
high blood pressure	☐	☐	heart disease	☐	☐
asthma	☐	☐	stroke	☐	☐
cancer	☐	☐	kidney disease	☐	☐
depression	☐	☐	mental illness	☐	☐
lung disease	☐	☐	substance abuse	☐	☐
diabetes	☐	☐	other _____		

SOCIAL HISTORY: Please indicate your tobacco, alcohol, caffeine, and dietary habits

Nicotine Use

- ☐ never smoked
- ☐ packs per day for ____ Years
- ☐ stopped ____ year(s) ago

Caffeine Intake

- ☐ never consumed
- ☐ drinks per day
- ☐ stopped ____ years(s) ago

Alcohol Consumption

- ☐ never consumed
- ☐ drinks per day/week
- ☐ stopped ____ year(s) ago

Diet Restrictions/Patterns

- ☐ number of meals per day
- ☐ food restrictions:_____

_____

OTHER INFORMATION/COMMENTS: