PATIENT HISTORY FORM

Note: 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 to do so.

Today's Date _____

Last Name _____ First Name _____ Date of Birth _____

Pharmacy _____ Primary Dr: _____ Referring Dr: _____

WHY ARE YOU HERE?

_____

_____

_____

Patient Height _____ Patient Weight _____

PAST MEDICAL & SOCIAL HISTORY

1.) List all your medical conditions. (Example: diabetes, tuberculosis, prostate cancer, heart disease, etc.)

_____

_____

_____

_____

_____

2.) List any personal surgeries and when occurred. Colonoscopy? Y N (if so when) _____

_____

_____

_____

_____

_____

3.) Are you on any medications? Y N (if yes, list all)

*****We are not part of Mosaic's system, please provide a current list of medications*****

_____

_____

_____

_____

_____

4.) Do you have allergies? Y N (if yes, list all and explain)

_____

_____

_____

5.) Tobacco use? Y N (if yes, how much) _____ previous use _____

Alcohol use? Y N (if yes, how much) _____

6.) List family medical conditions (Example: prostate cancer, bladder cancer, diabetes)

_____

_____

_____

REVIEW OF SYSTEMS

Do you now or have you had problems related to the following systems? Circle Y or N
Please explain any Yes answers in space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Endocrine

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other _____		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other _____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Hematologic/Lymphatic	Y	N
Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other _____		

Physician use only: (Comments/Notes)

//Answer	Level of Service
0	1 or 2
1-2	3
3	4 or 5

Signature _____ Date _____