INITIAL PATIENT HISTORY

Please complete before your appointment. Your answers will help the staff plan and provide your care. Leave blank any parts that you are unsure of, or that you do not wish to answer. We will review the form with you. The information will be kept confidential.

Today's Date: ____________________ **Location**: ____

Person completing this form (name): ____________________

❑ Patient ❑ Other (Relationship to Patient) __________

PATIENT NAME: ____________________________

Date of Birth: ______________ Age: ____________

Address: ________________________________

City: ____________________State: ______ Zip: _______

Home Phone: ( ) ____________________________

Work Phone: ( ) ____________________________

Cell Phone: ( ) ____________________________

E-Mail: ________________________________

MARITAL STATUS:

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

PREFERRED LANGUAGE: ❑ English

❑ Other______________________ ❑ Interpreter needed

RACE: ❑ Asian ❑ Black/African American

❑ Caucsian/White ❑ Mixed Race ❑ Other Race

Retired: ❑ Yes ❑ No Are you able to work: ❑ Yes ❑ No

Current Occupation: ____________________________

Employer: ________________________________

Primary Care Physician to whom you want medical records sent:

Name: ________________________________

Address: ________________________________

City: ________________________________

Please list any other physicians to whom you would like copies of information sent:

Name: ___________________Specialty: ___________

Address: ________________________________

City: _________________State:______ Zip: ___________

Name: ___________________Specialty: ___________

Address: ________________________________

City: _________________State: _____Zip: ___________

Please provide the medical reason for your appointment today: (when it started, symptoms, treatment): _________

____

____

____

____

Are there any religious, ethnic, or cultural practices that need to be part of your care: ❑ Yes ❑ No

(If you responded YES to the above question, a health professional will discuss this with you).

LIVING ARRANGEMENT:

❑ Alone ❑ With Spouse/Significant Other

❑ Supervised Living ❑ Other: ____________________

❑ I may need help with housing/change in living arrangements.

SERVICES IN YOUR HOME:

❑ None ❑ Family ❑ Aide ❑ Nurse ❑ Meals on Wheels

❑ IV Therapy ❑ Blood Glucose Monitor

❑ Continuous Oxygen ❑ Oxygen as needed

❑ Home Infusion Therapy

❑ Home Care Agency Name: ____________________

Home Care Agency Phone: ( ) ________________

❑ Other: ________________________________

ASSISTIVE DEVICES: I have: ❑ Cane ❑ Walker

❑ Wheelchair ❑ Scooter ❑ Hearing Aid

❑ Other: ________________________________

Please check boxes for items that you have:

❑ Organ Donor Card ❑Health Care Proxy

❑ Living Will/Advanced Directive*

❑ Power of Attorney ❑ Do Not Resuscitate Order

❑ Other ________________________________

YOUR PHARMACY:

Name: ________________________________

Address: ________________________________

Phone: ( ) ____________________________

Prescription: ____________________________

OFFICE USE ONLY

HEIGHT: _______________ WEIGHT: _____________

TPR: ___________________ BP: _______________

OTHER: ________________________________

SIGNATURE: ______________________________

BSA: _______ SIGNATURE: ____________________

*If no current Advanced Directive, information offered to the patient.

______________________________ _______________

SIGNATURE DATE/TIME

FAMILY HISTORY	Present Age	Age at Death	Present Health or Cause of Death
Father			
Mother			
❑ Brother ❑ Sister			
❑ Brother ❑ Sister			
❑ Brother ❑ Sister			
❑ Brother ❑ Sister			
❑ Brother ❑ Sister			
❑ Brother ❑ Sister			
❑ Son ❑ Daughter			
❑ Son ❑ Daughter			
❑ Son ❑ Daughter			
❑ Son ❑ Daughter			
❑ Son ❑ Daughter			
Malignancy in **Other** Family Members			
❑			
❑			
❑			
❑			

LIST ALL MEDICATIONS YOU NOW TAKE (include prescription, over-the-counter, and herbals):

Medication	Dose	How Often Taken	Allergies (List all (Medicine/Food/Other) and describe your reaction)

Patient's Name: ______________________________ **Date of Birth:** __________________

DO YOU NOW OR HAVE YOU EVER USED:

❑ Cigarettes ❑ Cigars
❑ Pipes ❑ Chewing Tobacco
❑ Snuff

Amount per Day: ________________
Started: Age: ________________
Stopped: Age: ________________

Would you like help to stop smoking?
❑ Yes ❑ No

Alcohol:

Beer (12 oz. can/bottle):
per day/week_____ # of years_____
Wine(4 oz. glass):
per day/week_____ # of years_____
Liquor (1 shot):
per day/week_____ # of years_____

If you quit drinking,
how old were you? _____

Would you like to talk to someone regarding your alcohol use:
❑ Yes ❑ No

Are you currently using recreational (street) drugs or illegal drugs/prescription drugs?
❑ Yes ❑ No
Type: ________________________

Would you like to talk to someone regarding your drug use?
❑ Yes ❑ No

LIST YEAR YOU LAST HAD:

_______Flu Vaccine/H1N1 Seasonal
_______Pneumonia Shot
_______Hepatitis Vaccine
_______T.B. Test
_______TetanusShot
_______Stool Blood Test
_______Digital Rectal Exam
_______Colonoscopy Exam
_______Eye Exam
_______Dental Exam

INFECTION HISTORY:

Have you ever been in isolation in the hospital?
❑ Yes ❑ No

Have you ever been told that you had a germ or organism that was difficult to treat with antibiotics?
❑ Yes ❑ No

Do you have a history of:
❑ MRSA ❑ VRE
❑ Hepatitis ❑ ESBL

FOR WOMEN ONLY

Date of last menstrual period: ___________
Do you have any reason to think you may be pregnant? ❑ Yes ❑ No
Are you breast feeding? ❑ Yes ❑ No
Age when menstrual period started? ______
Age when stopped? ________________
Any bleeding between periods?
❑ Yes ❑ No
Have you ever taken birth control pills?
❑ Yes ❑ No
How long? ___________ Years
Do you now use Birth Control Pills?
❑ Yes ❑ No
If Yes, Type: ________________
Are you currently taking hormone replacements?
❑ Yes ❑ No
Number of Pregnancies? ____________
Number of Live Births? ____________
Number of Abortions? ____________
Number of Miscarriages? ____________
Year of Last:
Pap Test ___________
❑ Normal ❑ Abnormal
Breast Exam ________
❑ Normal ❑ Abnormal
Mammogram________
❑ Normal ❑ Abnormal

Prior Cancer Treatment Have you ever had cancer, or do you now have cancer? ❑ Yes ❑ No

Type of Cancer (Body Part With Cancer	Year Diagnosed	Treatment	Name of Treating Physician
1.		❑ Surgery ❑ Radiation ❑ Chemotherapy	
2.		❑ Surgery ❑ Radiation ❑ Chemotherapy	
3.		❑ Surgery ❑ Radiation ❑ Chemotherapy	
4.		❑ Surgery ❑ Radiation ❑ Chemotherapy	

Patient's Name: ________________________ Date of Birth: ______________

MEDICAL HISTORY Please check **ALL** previous illnesses or conditions below. If you want to discuss any answer with the doctor, also **circle** the box. HAVE YOU **EVER** HAD:	YES	NO	**HOSPITALIZATIONS** Please list those operations or serious illnesses that you have had which required hospitalization. **Do not include pregnancies here.**	
A Heart Condition	❑	❑	**Month/Year**	**Illnesses**
High Blood Pressure	❑	❑	1.	
Rapid or Irregular Heartbeat (if yes, circle one)	❑	❑	2.	
A Stroke	❑	❑	3.	
A Lung Disorder (asthma/bronchitis/emphysema)	❑	❑	4.	
Stomach/Gall Bladder Problems	❑	❑	5.	
Jaundice/Hepatitis/other Liver Disorders	❑	❑	6.	
Ulcerative Collitis/Crohn's Disease	❑	❑	7.	
Kidney/Bladder Problems	❑	❑	8.	
A.I.D.S./H.I.V.	❑	❑	9	
Veneral Disease/Herpes	❑	❑	10.	
Arthritis/Chronic Pain	❑	❑	11.	
Frequent Headaches	❑	❑	12.	
Nervous Disorder	❑	❑		
Seizure Disorder	❑	❑	**Please provide more information below for the conditions or illnesses in which you have checked "yes".**	
Depression	❑	❑		
A Thyroid Problem	❑	❑		
Diabetes	❑	❑		
Eczema/Psoriasis	❑	❑		
Breast/Prostate Problems	❑	❑		
Anemia/Blood Problems	❑	❑		
A Blood Transfusion #_____________ Reactions	❑	❑		
Blood Clots: ❑ Lung ❑ Legs				
Asthma/Hives	❑	❑		
Birth Defects/Inherited Diseases	❑	❑		
Chicken Pox	❑	❑		
Measles/Mumps/Rubella	❑	❑		
Other	❑	❑		
❑ **No Known Medical Problems**				

PSYCHOSOCIAL SCREEN

Would you like to talk to someone about financial concerns?	Yes No	Yes No	Yes No	Yes No	Yes No
Do you have cultural or ethnic concerns that impact your care?	Yes No	Yes No	Yes No	Yes No	Yes No
Are you in a relationship or situation where you are physically hurt, threatened, exploited, or made to feel afraid?	Yes No	Yes No	Yes No	Yes No	Yes No

Patient's Name: ______________________________ **Date of Birth:** __________________

REVIEW OF SYSTEMS: ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? CHECK ALL THAT APPLY.

CARDIOVASCULAR
- ❑ Heart Murmur
- ❑ Rapid/Irregular Heart Rate
- ❑ Chest Pain
- ❑ Pacemaker/Defibrillator
- ❑ Ankle Swelling
- ❑ Leg Cramps at Night
- ❑ Other: ____________________

HEMATOLOGIC/LYMPHATIC
- ❑ Easy Bleeding/Bruising
- ❑ Prior Transfusions/Number Units ______
- ❑ Anemia or Blood Problems
- ❑ Frequent Infections
- ❑ Swelling Lymph Nodes (Neck/Groin)
- ❑ Other: ____________________

GASTROINTESTINAL
- ❑ Heartburn or Indigestion
- ❑ Stomach Discomfort
- ❑ Frequent Nausea/Vomiting
- ❑ Recurrent Diarrhea
- ❑ Constipation
- ❑ Gassy/Bloating
- ❑ Yellow Skin or Eyes
- ❑ Bloody Stools
- ❑ Black, Tarry Stools
- ❑ Other: ____________________

GENITOURINARY
- ❑ Blood in Urine
- ❑ Burning
- ❑ Frequency
- ❑ Dribbling
- ❑ Unable To Control Bladder
- ❑ Recurrent Bladder Infection
- ❑ Vaginal Itching/Discharge
- ❑ Other: ____________________

MUSCULOSKELETAL
- ❑ Trauma
- ❑ Joint Aches Or Stiffness
- ❑ Joint Swelling
- ❑ Back Pain
- ❑ Leg Cramps
- ❑ Artificial Limb ______________
- ❑ Other: ____________________

CONSTITUTIONAL
- ❑ Fevers ❑ Night Sweats
- ❑ Excessive Itching ❑ Fatigue
- ❑ Change In Sleep Habits
- ❑ Other: ____________________

NEUROLOGIC
- ❑ Difficulty Concentrating
- ❑ Headache/Migraines
- ❑ Dizziness/Fainting
- ❑ Numbness/Tingling of Hands/Feet
- ❑ Memory Changes
- ❑ Confusion
- ❑ Other: ____________________

ENDOCRINE
- ❑ Cold Intolerance
- ❑ Hot Flashes
- ❑ Other: ____________________

RESPIRATORY
- ❑ Shortness of Breath
- ❑ Frequent Coughing
- ❑ Wheezing
- ❑ Bloody Phlegm/Sputum
- ❑ Sleep Apnea (CPAP/BiPAP)
- ❑ Other: ____________________

NUTRITION
- ❑ Loss of Appetite
- ❑ Recent Weight Loss/Amount _______
- ❑ Recent Weight Gain/Amount _______
- ❑ Difficulty Chewing or Swallowing

Circle all that apply
(Hard Solid, Soft Solid, Liquid, Saliva)
- ❑ IV Nutrition (TPN)
- ❑ Tube Feedings
- ❑ Food Supplements (Vitamins/Minerals/Herbs)
- ❑ On a Diet Now ❑ Yes ❑ No

Type ________ # of Meals Daily _______
- ❑ Other: ____________________

ACCESS DEVICES

Do you have a catheter, tube, or port in your arm, chest, or abdomen for drawing blood, receiving medication, or removing fluid?

❑ Yes ❑ No

❑ Catheter ❑ Port ❑ Drainage Tube

SKIN
- ❑ Sores/Rashes
- ❑ Change In Moles
- ❑ Changes In Skin Color
- ❑ Body Piercing/Tattoos
- ❑ Other: ____________________

BREAST
- ❑ Nipple Discharge
- ❑ Change In Breast Size
- ❑ Lump/Pain
- ❑ Other: ____________________

HEAD & NECK
- ❑ Hearing Loss/Change
- ❑ Dentures
- ❑ Dental Problems
- ❑ Sores in Mouth
- ❑ Hoarseness
- ❑ Nose Bleeds
- ❑ Eye Glasses/Contacts
- ❑ Eye Disease (Glaucoma/Cataracts)
- ❑ Circle all that apply
- ❑ Vision Loss/Change
- ❑ Other: ____________________

PSYCHOLOGICAL
- ❑ Worried/Anxious
- ❑ Sad/Depressed
- ❑ Sleep Disturbance
- ❑ Feeling Overwhelmed
- ❑ Confused
- ❑ Have you had thoughts of hurting yourself in the last month?

MALE ONLY
- ❑ Enlarged Prostate
- ❑ Date of Last Prostate Exam: ______________
- ❑ Date of Last PSA Lab Test: ______________

SEXUALITY/INTIMACY
- ❑ Concerns About Sexual/Reproductive Issues
- ❑ Intimacy
- ❑ Other: ____________________

Patient's Name: ___________________________ Date of Birth: ________________

COMFORT/PAIN ASSESSMENT:

Do you have pain now? ❑ Yes ❑ No

Are you being treated for this pain? ❑ Yes ❑ No If Yes, By Whom: ______________________________

Have you had pain in the past week? ❑ Yes ❑ No If Yes, Please Describe: __________________________

____

How long does it last? ____

What makes your pain feel better? ____

What makes your pain worse? ____

What treatment or medications are you receiving for your pain? ______________________________________

____

Is this regimen effective? ❑ Yes ❑ No

Thank you for providing the staff with the information that will help us in planning your care.

__________________________ Or __________________________ ______________

Signature of Patient **Signature of Guardian and Relationship** **Date/Time**

Reviewed by: ______________________________ **Date & Time ______________________**

(Physician Signature)

Reviewed by: ______________________________ **Date & Time ______________________**

(Other Signature RN, PA)

Patient's Name: ______________________________ **Date of Birth: __________________**