

Clermont Medical Center PA

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Patient History Form

Primary Care Provider: _____ Appt Date: _____

Patient Name: _____ DOB: _____

What medications are you taking now? (use last page for additional medications)

_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Doaage _____

What vitamins are you taking and dosage?

Are you allergic to any medication? NO YES, if yes please list medication and the reaction

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

Past Medical History and Current History:

Cancer: _____ When: _____ Comment: _____
Cancer: _____ When: _____ Comment: _____
Diabetes: _____ When: _____ Comment: _____
Heart Attack: _____ When: _____ Comment: _____
Heart Failure: _____ When: _____ Comment: _____
Stroke: _____ When: _____ Comment: _____
High Cholesterol: _____ When: _____ Comment: _____
High Blood Pressure: _____ When: _____ Comment: _____

Sleep Apnea: _____ When: _____ Comment _____

Thyroid Disease: _____ When: _____ Comment: _____

Other: _____ When: _____ Comment: _____

For Men Only:

When was your last (please list the date)

Physical _____ PSA (lab work) _____ Colonoscopy _____ Lab work _____

Vaccines:

Pneumonia _____ Influenza _____ Shingles: _____ Tetanus _____

For Women Only:

When was your last (please list the date)

Physical _____ Pap Smear _____ Mammogram _____ Colonoscopy _____

Lab Work _____ DEXA _____

Vaccines:

Pneumonia: _____ Influenza: _____ Shingles: _____ Tetanus: _____

Have you ever been pregnant? Yes NO

Number of miscarriages _____ Number of abortions _____ Number of termed births _____

Are you in menopause? If yes , age at last period: _____

Do you take: Estrogen _____ Ogen _____ Estrace _____ Premarin _____ Progesterone _____

Provera _____ Other (specify) _____

How long have you been on hormone replacement therapy? (if applicable) _____

Surgical History: Year Comments

Appendectomy: _____

Dental Surgery: _____

Gallbladder: _____

Hernia: _____

Hysterectomy: _____

Tonsillectomy: _____

Other (describe) _____

Other (describe) _____

Hospitalizations: Only list overnight hospitalizations other than surgery or childbirth

Where	When	What Reason

Physicians you are currently seeing

Name	Specialty

Family History:

Father age if alive ___ age of death ___ Cause of death _____
Hypertension ___ Cancer ___ Cardiac ___ Asthma ___ Diabetes ___ Alzheimer/Dementia ___

Mother age if alive ___ age of death ___ Cause of death _____
Hypertension ___ Cancer ___ Cardiac ___ Asthma ___ Diabetes ___ Alzheimer/Dementia ___

Brother age if alive ___ age of death ___ Cause of death _____
Hypertension ___ Cancer ___ Cardiac ___ Asthma ___ Diabetes ___ Alzheimer/Dementia ___

Sister age if alive ___ age of death ___ Cause of death _____
Hypertension ___ Cancer ___ Cardiac ___ Asthma ___ Diabetes ___ Alzheimer/Dementia ___

Son age if alive ___ age of death ___ Cause of death _____
Hypertension ___ Cancer ___ Cardiac ___ Asthma ___ Diabetes ___ Alzheimer/Dementia ___

Daughter age if alive ___ age of death ___ Cause of death _____
Hypertension ___ Cancer ___ Cardiac ___ Asthma ___ Diabetes ___ Alzheimer/Dementia ___

Paternal Grandfather age if alive____ age of death____ Cause of death_____

Hypertension___ Cancer___ Cardiac ___Asthma ___ Diabetes ___ Alzheimer/Dementia___

Paternal Grandmother age if alive____ age of death____ Cause of death_____

Hypertension___ Cancer___ Cardiac ___Asthma ___ Diabetes ___ Alzheimer/Dementia___

Maternal Grandfather age if alive____ age of death____ Cause of death_____

Hypertension___ Cancer___ Cardiac ___Asthma ___ Diabetes ___ Alzheimer/Dementia___

Maternal Grandmother age if alive____ age of death____ Cause of death_____

Hypertension___ Cancer___ Cardiac ___Asthma ___ Diabetes ___ Alzheimer/Dementia___

Other Diseases: _____

Tobacco:

Have you ever used tobacco? No Yes If Former what year you quit _____

If yes, everyday? _____

How many cigarettes a day?

5 or less_____ 6-10_____ 11-20_____ 21-30_____ 31 or more_____

How soon after you wake do you smoke your first cigarette?

Within 5 mins_____ 6-30 min_____ 31-60 min _____ after 60 min _____

Are you interested in quitting?

Ready to quit _____ Thinking about quitting _____ Not ready to quit _____

Alcohol:

Did you have a drink containing alcohol in the past year? Yes No

If yes how often

Monthly or less_____ 2-4 times a month_____ 2-3 times a week_____ more than times a week_____

How many drinks did you have on a typical day when you were drinking in the past year?

1-2 drinks_____ 3-4 drinks_____ 5-6 drinks_____ 7-9 drinks_____ 10 or more drinks _____

How often did you have 6 or more drinks on one occasion in the past year?

Never___ less than monthly___ Monthly___ Weekly___ Daily or almost daily _____

Depression:

Are you feeling down, depressed or hopeless? Yes No

Do you feel little interest or pleasure in doing things? Yes No

Have you ever used recreational drugs No Yes (if yes what and when)_____

How much caffeine daily? _____

Review of Symptoms (Please indicate if you have any of the following)

General:

Fever/chills ___ Malaise ___ Fatigue ___ Night sweats ___ Headache ___ Weight change ___

Eyes:

Change in vision ___ Blurring ___ Double vision ___ Pain ___ Date of last eye exam ___

Ears:

Hearing loss ___ pain ___ Discharge ___ Ringing ___

Nose:

Loss of smell ___ Obstruction ___

Throat:

Hoarseness ___ Frequent sore throats ___ Sore/bleeding gums ___ Toothaches ___ Change in taste ___

Dentures:

Upper ___ Lower ___ Full ___ Partial ___

Endocrine:

Thyroid enlargement ___ Pain ___ Tenderness ___ Weight change ___ Heat or Cold intolerance ___

Excessive thirst ___

Respiratory:

Pain ___ Shortness of Breath ___ Wheezing ___ Cough ___ Sputum Production ___

Coughing up blood ___ Exposure to TB ___ Date of last chest Xray ___

Cardiac:

Chest Pain ___ Palpitations ___ Ankle Swelling ___ Leg Cramps ___ High blood pressure ___

Other heart Problems ___ Date of last EKG: _____ Other heart tests _____

Gastrointestinal:

Change in appetite ___ Food intolerance ___ Heartburn ___ Nausea ___ Vomiting ___ Hernia ___

Constipation ___ Diarrhea ___ Black or bloody stools ___ Gallstones ___ Cirrhosis ___

Hepatitis ___ Jaundice ___

Hematology:

Anemia ___ Bleeding problems ___ Blood clots ___

Transfusions _____ Date: _____ Reason: _____

Female:

Breast lumps ___ breast pain ___ Discharge from breast ___

