

PATIENT HISTORY FORMS FOR OUTPATIENT CONSULTATION

Patient Instructions:

1. Fill out all other forms including this one to get you registered. Print this one out and then go to *forms* to get your financial and demographic forms completed.
2. Try to get all the records that relate to the reason you are being referred to us from your doctors and mail or fax them to us. This is far better than asking the doctor's office, as the request may not cause this to occur, i.e. we may not receive your information. It is especially important if there are particular bacterial cultures relating to your infectious disease problem.
3. Please bring a list of all the medicines prescribed and non-prescribed. This should include the dose and the frequency that you are taking them. Additionally, I would bring all your current prescription medications with you in a plastic baggie each time you come to the doctor.
4. Fill out the following forms in their entirety. Use the back of each form if you need the space.
5. Please bring a complete list of your immunizations including all dates.
6. Bring a list of all your current doctors including their addresses, phone numbers, fax and e-mail if available to you.
7. Bring a list of your current pharmacy with the phone number.

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Social History

Tobacco:
(Circle which is correct)

Never smoked Smoked but quit Still smoking

Years smoked: _____

Date of onset: _____ Packs per day: _____

Alcohol:
(Circle which is correct)

Never Occasional Frequent

DWI? Yes No

Rehab for alcohol? Yes No

Drinks per day: _____

Educational level reached: _____

Immunization History:
See instruction to bring a complete list of all adult immunizations you have received. List boosters on the same number. For example, if you received the influenza vaccine from 2000 to the present, it would all be listed under 1 number.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

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Marital History

Circle which is correct:

Divorced Never Married Widow or widower

Number of times married: _____

Health of current spouse: _____

Family History

Mother: _____ Living Age: _____

Deceased age at death: _____ Cause of death: _____

If living, state of current health: _____

Father: _____ Living Age: _____

Deceased age at death: _____ Cause of death: _____

If living, state of current health: _____

Siblings:

Number of brothers: _____ Number of sisters: _____

Any deceased and cause of death: _____

Diseases that run in your family: (Circle)

Frequent Severe

More than one member of your family which would include mother, father, siblings, grandparents and aunts and uncles:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Review of Systems

This part of the questionnaire attempts to discover how all the various parts of your body are working.

My health is:
(Circle which is correct)

Excellent Good Fair Poor

If you circled fair or poor please give the major reason you selected that option:

Skin

All of us have minor skin problems. Please address boils or skin infections, or any skin cancers.

Have you visited a skin doctor a dermatologist? _____

Are you on medication from a skin doctor or from your personal doctor for a skin condition?

Bones muscle joints

Please comment and list any of the following: Rheumatism, arthritis, visits to a joint doctor either a rheumatologist or an orthopedist.

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Are you taking medicine for arthritis? _____

Joint replacements, if any:

Date: _____ Surgeon: _____

Complication: _____

Other: _____

Lupus Fibromyalgia? _____

Blood

Have you ever had anything wrong with your red blood cells, white blood cells, or platelets?

Circle those that apply:

Anemia Endocrine Gland problems Diabetes Thyroid Other

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Head Ears Eyes Nose or throat

Circle those that apply:

- Frequent or severe headaches Hearing or ear problems Throat cancers
- Sinus problems-sinus surgery Oral problems other than dental
- Neck masses or thyroid troubles

Chest Respiratory

Tobacco: _____

Other unusual dust exposure: _____

Asthma: _____

Pneumonia: _____

Abnormal Chest X-ray: _____

History of Tuberculosis in family or positive TB skin test in you:

Shortness of breath or sleep apnea: _____

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Heart

Circle those that apply:

- | | |
|--------------------------|-----------------------------|
| Congenital Heart Disease | Myocarditis or Pericarditis |
| Angina or Heart Attack | Heart Failure or Dropsy |
| Irregular Heart Action | Bad Blood Flow to your legs |

Pain when walking for short distances

Breasts

Women unless Men have had malignancy.

Circle those that apply:

Breast Cancer Mastitis Lumps

Biopsies: _____

Stomach and Liver: _____

Acid Reflux Heartburn: Taking meds for this? _____

Circle those that apply:

- | | | |
|-------------------------------|---------------------------|----------------------|
| Stomach Ulcers | Gall Bladder Problems | Gall Bladder Surgery |
| Hernia or Intestinal Blockage | Inability to absorb Foods | |
| Frequent Nausea or Diarrhea | | |

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Colon

If greater than age 50:

Date of last colonoscopy: _____

Circle those that apply:

- | | | |
|------------------|--------------------------|----------------------------|
| Colon Cancer | Diverticulosis | Inflammatory Colon Disease |
| Genitourinary | Urinary tract infections | Kidney Stones |
| Bad or decreased | Kidney function | Prostate Problems-Men |
| Gynecological | Abnormal Pap Smear | Hysterectomy |

Other Female Surgery of any Type: _____

Circle those that apply:

- | | | |
|---------------------|------------------------------------|------------------------------|
| Neurological | Seizure Disorder | Frequent or severe headaches |
| Alzheimer's | Other Degenerative Nervous Disease | |
| Psychiatric Disease | | |

Depression? _____

Hospitalization? _____