PATIENT HISTORY - PLEASE COMPLETE ENTIRE FORM
(COMPLETE IN BLACK INK ONLY)

PATIENT LABEL

Date of Birth ________________ Age at this visit ________________

Family Physician / Primary Care Provider ________________________________

Specialist: ________________________________

____

____

____

PAST MEDICAL HISTORY:

Have you ever been diagnosed with or experienced the following? CHECK YES or NO TO EACH ITEM

ALLERGIC/IMMUNOLOGIC:

Yes No
- ☐ ☐ Seasonal / Environmental allergies
- ☐ ☐ Contact dermatitis
- ☐ ☐ HIV/Immunosuppressive Disorders

CARDIOVASCULAR:

Yes No
- ☐ ☐ Irregular heartbeat
- ☐ ☐ High blood pressure
- ☐ ☐ Congestive heart failure
- ☐ ☐ Mitral valve prolapse
- ☐ ☐ Varicose veins
- ☐ ☐ Heart disease
- ☐ ☐ Heart murmur
- ☐ ☐ Heart attack
- ☐ ☐ Pacemaker
- ☐ ☐ Implantable defibrillator
- ☐ ☐ Peripheral vascular disease
- ☐ ☐ AV shunt for dialysis Rt Lt

HEMATOLOGIC/LYMPHATIC:

Yes No
- ☐ ☐ Bleeding disorder
- ☐ ☐ Blood clots in lungs or legs
- ☐ ☐ Cancer: Type ________
- ☐ ☐ Clotting disorder
- ☐ ☐ Previous transfusions
- ☐ ☐ Anemia

MUSCULOSKELETAL:

Yes No
- ☐ ☐ Previous fractures
- ☐ ☐ Previous muscle or tendon injury
- ☐ ☐ Osteoarthritis
- ☐ ☐ Rheumatoid arthritis
- ☐ ☐ Scleroderma
- ☐ ☐ Fibromyalgia
- ☐ ☐ Lupus
- ☐ ☐ Scoliosis

INTEGUMENTARY / SKIN:

Yes No
- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Scars
- ☐ ☐ Tattoos
- ☐ ☐ Body Piercing

METABOLIC / ENDOCRINE:

Yes No
- ☐ ☐ Irregular menstrual cycles
- ☐ ☐ Diabetes ☐ Insulin ☐ Non-insulin
- ☐ ☐ Hypoglycemia
- ☐ ☐ Gout
- ☐ ☐ Hypothyroidism
- ☐ ☐ Hyperthyroidism
- ☐ ☐ Hyperparathyroidism
- ☐ ☐ Hashimotos goiter
- ☐ ☐ Paget's disease

EYES / EARS:

Yes No
- ☐ ☐ Deafness Rt Lt
- ☐ ☐ Hard of hearing / hearing aid
- ☐ ☐ Cataracts
- ☐ ☐ Glaucoma
- ☐ ☐ Blindness
- ☐ ☐ Glasses
- ☐ ☐ Contacts

NEUROLOGIC:

Yes No
- ☐ ☐ Alzheimer's disease
- ☐ ☐ Parkinson's disease
- ☐ ☐ Stroke
- ☐ ☐ Seizure disorder

PULMONARY:

Yes No
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ TB or exposure

GASTROENTEROLOGIC:

Yes No
- ☐ ☐ Gastric reflux
- ☐ ☐ Ulcer disease
- ☐ ☐ Irritable bowel syndrome
- ☐ ☐ Crohn's or ulcerative colitis
- ☐ ☐ Hiatal hernia
- ☐ ☐ Cirrhosis
- ☐ ☐ Hepatitis A B C

RENAL/GU:

Yes No
- ☐ ☐ Kidney disease impairment
- ☐ ☐ Dialysis
- ☐ ☐ Kidney stones
- ☐ ☐ Prostate problems
- ☐ ☐ Frequent urinary tract infections

PSYCHOLOGIC:

Yes No
- ☐ ☐ Depression
- ☐ ☐ Anxiety disorder

Other: ________________________________

REVIEW OF SYSTEMS:

Are you experiencing any of the following? CHECK YES or NO TO EACH OF THE FOLLOWING

Yes No
- ☐ ☐ Increased energy
- ☐ ☐ Decreased energy
- ☐ ☐ Recent weight loss
- ☐ ☐ Recent weight gain
- ☐ ☐ Generalized weakness
- ☐ ☐ Fever for unknown reason
- ☐ ☐ Chills
- ☐ ☐ Night sweats

Yes No
- ☐ ☐ Recent onset of high blood pressure
- ☐ ☐ Cold extremities
- ☐ ☐ Joint swelling
- ☐ ☐ Joint pain
- ☐ ☐ Numbness
- ☐ ☐ Tingling

Yes No
- ☐ ☐ Muscle pain with any activity or rest
- ☐ ☐ Back pain
- ☐ ☐ Rashes
- ☐ ☐ Headaches
- ☐ ☐ Blurred vision
- ☐ ☐ Shortness of breath
- ☐ ☐ Chronic cough

Yes No
- ☐ ☐ Problems breathing
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Poor bladder control
- ☐ ☐ Burning on urination
- ☐ ☐ Increased urinary frequency
- ☐ ☐ Depression

Other: ________________________________

***** PLEASE COMPLETE OTHER SIDE *****

PATIENT LABEL

PAST SURGICAL HISTORY: (Please list ALL previous surgeries)

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

FAMILY HISTORY - IMMEDIATE FAMILY - NOT PATIENT

History of ( ) Heart disease ( ) Heart attack ( ) Lung disease ( ) Diabetes ( ) Rheumatoid arthritis ( ) Cancer
( ) Stroke ( ) TB ( ) Anesthesia complications ( ) Patient adopted - no history available ( ) No Problems
( ) Blood clots in lungs or legs ( ) Other: ______________________

SOCIAL HISTORY

Marital Status: ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed

Available Assistance and Support:

Do you live in: ( ) House/ Apartment ( ) Assisted living ( ) Residential care home ( ) Other: ____________

Number of dependent children ____________

Do you use, or have you ever used:

Tobacco: ( ) Yes ( ) No ( ) Rarely ( ) Occasionally ( ) Regularly ____________ packs per day
Alcohol: ( ) Yes ( ) No ( ) Rarely ( ) Occasionally ( ) Regularly ____________ drinks per day
Recreational drugs: ( ) Yes ( ) No Explain ______________________
IV drugs: ( ) Yes ( ) No Date last used: ______________________

PREVIOUS DIAGNOSTIC STUDIES: Did you bring them with you? ( ) Yes ( ) No

Test Done (i.e. MRI, CT scan, etc.)	Date Done	Facility (i.e. Memorial, Chattanooga Outpatient Center)	Films / Reports

PLEASE SIGN BELOW

The information provided by me on this form is true and accurate to the best of my knowledge.

Patient: ______________________ Date: ____________

Nurse/MA Initials: ______ Date: ____________ Provider Signature: ______________________ Date: ____________