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**Patient history form**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Give thoughtful, brief answers to the following items. Leave blank or write "NA" for those sections not applicable.

Chief **problem** or symptom briefly stated: \_\_\_\_\_

What **seemed to cause** or lead up to the problem? \_\_\_\_\_

Date Started \_\_\_\_\_ Intermittent or constant: \_\_\_\_\_

Triggered by? \_\_\_\_\_ Frequency (# of episodes)? \_\_\_\_\_

**Associated body symptoms:** \_\_\_\_\_

Prior tests, evaluations for this (when and where): \_\_\_\_\_

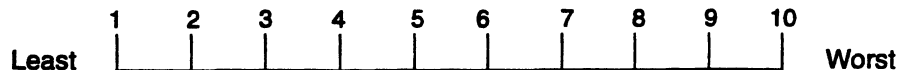
**Treatments** you've already tried & their effectiveness? \_\_\_\_\_

**Name of doctor** who referred you or who has been treating you? \_\_\_\_\_

Anything similar in family members or co-workers? Family history of? \_\_\_\_\_

Any habits that might have contributed to this problem? \_\_\_\_\_

How **severe** or bothersome is the problem on a scale from 1 to 10? *Please mark the following scale*



Anything else you would like to add that you feel might help us understand this problem better? \_\_\_\_\_

Are you **ALLERGIC TO MEDICATIONS** or have you had a bad reaction to any medications, please describe:

List **CURRENT DRUGS** (blood thinners, steroids, over-the-counter medications) that you are taking: \_\_\_\_\_

Do you **BLEED ABNORMALLY** for a long time following a cut or do you bleed easily? Please circle: YES NO

Does anyone in your immediate family have a bleeding disorder? Please circle: YES NO

Do you have any **ADULT ILLNESS** (high blood pressure, diabetes, heart disease, etc.), please describe:

Do you smoke? Please circle YES NO  
If yes, approx. how much: \_\_\_\_\_

Do you use alcohol? Please circle YES NO  
If yes, approx. how much: \_\_\_\_\_

Is there a possibility that you are pregnant? YES NO Occupation: \_\_\_\_\_

Any unusual **CHILDHOOD DISEASES**, please describe: \_\_\_\_\_

Do you have any **ALLERGIES** such as hay fever, asthma or food allergies, please describe: \_\_\_\_\_

Please list surgical **PROCEDURES** and **HOSPITALIZATIONS** (place, date, reason): \_\_\_\_\_

**FAMILY HISTORY:** (please check any of the following diseases that seem to run in your family or have occurred in any related family member)

- |  |  |
|--|--|
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Skin Cancer       | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Hay fever         | <input type="checkbox"/> Diabetes      |
| <input type="checkbox"/> Eczema            | <input type="checkbox"/> Miscellaneous |

**SYSTEMS REVIEW:** (please check any of the following problems that you have had or currently have)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Recent weight gain           | <input type="checkbox"/> Trouble breathing        |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Recent weight loss           | <input type="checkbox"/> During day               |
| <input type="checkbox"/> Measles                | <input type="checkbox"/> Change in appetite           | <input type="checkbox"/> During night             |
| <input type="checkbox"/> Mumps                  | <input type="checkbox"/> Food allergies               | <input type="checkbox"/> During exercise          |
| <input type="checkbox"/> Chicken Pox            | <input type="checkbox"/> Stomach trouble              | <input type="checkbox"/> High blood pressure      |
| <input type="checkbox"/> Rheumatic fever        | <input type="checkbox"/> Ulcers                       | <input type="checkbox"/> Heart Attack             |
| <input type="checkbox"/> Epilepsy               |   | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Pneumonia              | <input type="checkbox"/> Broken bones                 | <input type="checkbox"/> Heart trouble            |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Chronic pain                 | <input type="checkbox"/> Coughing blood           |
|   |   | <input type="checkbox"/> Blood in urine           |
| <input type="checkbox"/> Convulsions            | <input type="checkbox"/> Nervous breakdown            | <input type="checkbox"/> Kidney stone             |
| <input type="checkbox"/> Seizures or fits       | <input type="checkbox"/> Depression                   | <input type="checkbox"/> Painful urination        |
| <input type="checkbox"/> Severe headaches       | <input type="checkbox"/> Anxiety                      | <input type="checkbox"/> Bladder infection        |
| <input type="checkbox"/> Frequent headaches     | <input type="checkbox"/> Seen a psychiatrist          |   |
| <input type="checkbox"/> Fainting episodes      |   |   |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Menstrual problems           |   |
|   | <input type="checkbox"/> Abnormal vaginal bleeding    | <input type="checkbox"/> Sinus infection          |
| <input type="checkbox"/> Hearing problems       | <input type="checkbox"/> Venereal disease             | <input type="checkbox"/> Easy bleeding            |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Syphilis                     | <input type="checkbox"/> Easy bruising            |
| <input type="checkbox"/> Joint Pain or Swelling | <input type="checkbox"/> Gonorrhea                    | <input type="checkbox"/> Anemia                   |
|   |   |   |
| <input type="checkbox"/> Trouble swallowing     | <input type="checkbox"/> Poor vision                  | <input type="checkbox"/> Gall bladder trouble     |
| <input type="checkbox"/> Frequent sore throats  | <input type="checkbox"/> Sores that don't heal        | <input type="checkbox"/> Bowel trouble            |
| <input type="checkbox"/> Swollen neck glands    | <input type="checkbox"/> Ankle swelling               | <input type="checkbox"/> Liver disease            |
| <input type="checkbox"/> Thyroid problems       | <input type="checkbox"/> Skin cancer - Please Specify | <input type="checkbox"/> Yellow jaundice          |
| <input type="checkbox"/> Hoarseness             | <input type="checkbox"/> Basal Cell                   | <input type="checkbox"/> Blood in bowel movements |
|   | <input type="checkbox"/> Squamous Cell                |   |
|   | <input type="checkbox"/> Melanoma                     |   |
|   | <input type="checkbox"/> Precancers on skin           |   |
|   | <input type="checkbox"/> Eczema                       |   |
|   | <input type="checkbox"/> Hay Fever                    |   |