Clermont Medical Center

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Patient History Form

Name: ______________________________ Date: ______________________

Social Sec. No. ________________ Sex: _______ Marital Status: ______________

Address:_____________________________City_____________ State___ Zip:_____________

Home Phone: (____)_____________ Cell Phone: (___)_____________Work: (___)________________

Birth Date: ___/___/_____ Age: _____ Place of Birth: ____________ Occupation_________________

Email:_________________________ Pharmacy:____

Please check appropriate box (es):

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian

☐ Native American ☐ Caucasian ☐ Northern European ☐ Other _________

What medications are you taking now?

Medication Name	Dosage

List all vitamins and other supplements that you are taking.

Vitamins/Supplements Name	Dosage

❖ **Are you allergic to any medications?** No ☐ Yes ☐ If yes, please list and reaction.

Medication	Reaction

Past Medical History and Current History:

ILLNESSES	WHEN	COMMENTS
Cancer		
Diabetes		
Heart Attack/Angina		
Heart Failure		
Stroke		
High blood fat (Cholesterol/Triglycerides)		
High blood pressure (Hypertension)		
Sleep Apnea		
Thyroid Disease		
Other(describe):		

For Men Only:

When was your last: (Please list the date)
Physical ________________
PSA ________________
Colonoscopy ________________
Flu shot ________________

Pneumonia shot
PPSV23(Pneumovax)_________ PCV13(Prevnar)_________
Shingles shot __________________
Tetanus injection __________________
AAA screen (smoking History) ______________

For Women Only:

When was your last: (Please list the date)
Physical _____________
Pap Smear ____________
Mammogram____________
Colonoscopy ________
Flu Shot ________________

Pneumonia shot
PPSV23(Pneumovax)_________PCV13(Prevnar)_________
Shingles shot __________________
Tetanus injection __________________
DEXA (Bone density test) __________________

Have you ever been pregnant? ____ No ______ Yes If yes:
Number of miscarriages ______ Number of abortions _____ Number of term births______
Have you ever used birth control pills? _____No _____ Yes If yes, when:_____________________
Are you in menopause? _____No _____Yes If yes, age at last period __________________________
Do you take:
Estrogen?____ Ogen?____ Estrace?_____ Premarin?_____ Other (specify) ___________________
Progesterone? _____ Provera? ______ Other (Specify) __________________
How long have you been on hormone replacement therapy (if applicable)? _________________________

Surgery History:

	Year	Comments
Appendectomy		
Dental Surgery		
Gallbladder		
Hernia		
Hysterectomy		
C-Section		
Tonsillectomy		
Other (describe):		

Hospitalizations: Please list only overnight hospitalizations other than surgery or child birth.

Where Hospitalized	When	For what reason

Family History:

Relative:	Age if alive	Age of death	Cause of death	HBP	Cancer	Cardiac problems	Asthma	Diabetes	Alzheimer's or Dementia	Other
Father										
Mother										
Brothers										
Sisters										
Spouse										
Son										
Daughter										
Paternal Grandfather										
Paternal Grandmother										
Maternal Grandfather										
Maternal Grandmother										

Other diseases: ____
____

- **Have you ever used tobacco**? _____No _____Yes Year quit: __________

If yes: every day? ____ some days, but not every day? _________

How many cigarettes a day?

___ 5 or less _____ 6-10 ____ 11-20 ____21-30 ____31 or more

How soon after you wake up do you smoke your fist cigarette?

____within 5 minutes ____6-30 minutes ____31-60 minutes ____ after 60 minutes

Are you interested in quitting?

____Ready to quit ____Thinking about quitting ____ Not ready to quit

Tobacco used other than smoking? _____No _____Yes

- **Did you have a drink containing alcohol in the past year**? ____No ____Yes

If yes how often:

____monthly or less ____2-4 times a month ____2-3 times a week ___4 or more 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

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 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: __________
Did they change your Rx? ______________________________________

Ears:

Hearing loss___ Pain___ Discharge___ Ringing___

Nose:

Loss of smell: __________________ Obstruction ________________________

Throat:

Hoarseness (Change in voice) ____ Frequent sore throats ____ Sore or 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 last Chest X-ray________ Reason________________

Cardiac:

Chest pain____ Palpitations_____ Ankle swelling____ Leg cramps____ High blood pressure_____
Other heart problems: _____________________Date of last ECG: _________other heart tests: __________

Gastrointestinal:

Change in appetite_______ Food intolerance_______ Heartburn______ Nausea_____ Vomiting______
Constipation_____ Diarrhea_____ Black or Bloody stools____ Gallstones____ Hernia ____
Cirrhosis_________ Hepatitis_________ Jaundice _______

Hematology:

Anemia____ Bleeding problems_______ Blood clots __________
Transfusions_____ Date___________ Reasons____

Female:

Breast lumps____ Breast Pain____ Discharge from the breast____
Menstruation: Heavy bleeding____ Irregular____ Missed menses____ Painful menses________
Vaginal bleeding between periods_____ Vaginal discharge ______
Hot flashes_______ Painful intercourse_____ Infertility______ Fibroids______ Ovarian cyst_____
Endometriosis_______

Male:

Discharge from penis____ Ejaculation problem___ Genital pain___ Impotence____ Infection___
Lumps in testicles____ Poor libido (sex drive) ____ Prostate enlargement____ Prostate infection____
Other prostate problem____

Lymphatic:

Swollen Lymph Nodes_____________ Pain__________________

Urinary:

Kidney or Bladder Stones____ Urinary Tract Infection____ Blood in Urine____ Painful Urination____
Frequency____ Dribbling_____ Decrease in Force of Stream________

Musculoskeletal:

Back pain___ Joint pain____ Leg pain____ Swelling in joints_____ Muscle spasm______
TMJ problems___________________ Weakness________________ Cramps____________________

Skin:

Rash ____ Eruptions____ Itching_____ Color Change_____ abnormal hair or nail growth_____

Mental:

Stroke________ Paralysis__________ Depression_________ Crying spells_______ Memory loss_____
Loss of balance ________________ Suicidal thoughts ____

Please comment on any other information you feel the doctor should know or discuss with you.