

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):

- | | | | |
|-------------------------------------------|------------------------------------|--------------------------------------------|--------------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> 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 _____	Pneumonia injection _____
PSA (lab work) _____	Zostavax (Shingles) _____
Colonoscopy _____	Tetanus injection _____
Flu shot _____	

For Women Only:

When was your last: (Please list the date)	
Physical _____	Pneumonia injection _____
Pap Smear _____	Zostavax (Shingles) _____
Mammogram _____	Tetanus injection _____
Colonoscopy _____	DEXA (bone density test) _____
Flu Shot _____	
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		
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	hypertension	Cancer	Cardiac problems	Asthma	Diabetes	Alzheimer's or dementia
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 ___
Giarrhosis ___ 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 _____
Hotflashes ___ 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.
