Clermont MEDICAL CENTER, PA – FAMILY PRACTICE –

PATIENT HISTORY

Comprehensive health history

Primary Care Provider

Appointment Date

Patient Name

DOB

1 CURRENT MEDICATIONS

Medication

Dosage

Medication

Dosage

Medication

Dosage

Medication

Dosage

Vitamins / supplements and dosage

2 ALLERGIES

☐ No known medication allergies ☐ Yes - list below

Medication

Reaction

Medication

Reaction

Medication

Reaction

3 DEPRESSION

1- Little interest or pleasure in doing things

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day
- ◯ Declined to specify

2- Feeling down, depressed, or hopeless?

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day
- ◯ Declined to specify

Clermont MEDICAL CENTER, PA – FAMILY PRACTICE –

PATIENT HISTORY

Past medical history & current conditions

4 PAST MEDICAL HISTORY AND CURRENT HISTORY

Condition		When	Comment
Cancer			
Cancer (additional)			
Diabetes			
Heart attack			
Heart failure			
Stroke			
High cholesterol			
High blood pressure			
Sleep apnea			
Thyroid disease			
Other			

Clermont MEDICAL CENTER, PA – FAMILY PRACTICE –

PATIENT HISTORY

Screening, vaccines & surgical history

5 FOR MEN ONLY

Last physical | PSA | Colonoscopy

Vaccines | Pneumonia | Influenza | Shingles | Tetanus

6 FOR WOMEN ONLY

Physical | Pap smear | Mammogram | Colonoscopy | Lab work

DEXA | Pneumonia | Influenza | Shingles/Tetanus

☐ Ever pregnant - Yes ☐ No Miscarriages Abortions Term births

Menopause? Age at last period

Hormone replacement / duration

7 SURGICAL HISTORY

	Year	Comments
Appendectomy		
Dental surgery		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Other		
Other		

Clermont MEDICAL CENTER, PA – FAMILY PRACTICE –

PATIENT HISTORY

Hospitalizations, physicians & family history

8 HOSPITALIZATIONS - OVERNIGHT OTHER THAN SURGERY OR CHILDBIRTH

Where	When	Reason

9 PHYSICIANS YOU ARE CURRENTLY SEEING

Name	Specialty

10 IMMEDIATE FAMILY HISTORY

Father Age alive/death _____ Cause _____

☐ Hypertension ☐ Cancer ☐ Cardiac ☐ Asthma ☐ Diabetes ☐ Alzheimer/Dementia

Mother Age alive/death _____ Cause _____

☐ Hypertension ☐ Cancer ☐ Cardiac ☐ Asthma ☐ Diabetes ☐ Alzheimer/Dementia

Brother Age alive/death _____ Cause _____

☐ Hypertension ☐ Cancer ☐ Cardiac ☐ Asthma ☐ Diabetes ☐ Alzheimer/Dementia

10 FAMILY HISTORY - CONTINUED

Sister Age alive/death ____ Cause ____

☐ Hypertension ☐ Cancer ☐ Cardiac ☐ Asthma ☐ Diabetes ☐ Alzheimer/Dementia

Son Age alive/death ____ Cause ____

☐ Hypertension ☐ Cancer ☐ Cardiac ☐ Asthma ☐ Diabetes ☐ Alzheimer/Dementia

Daughter Age alive/death ____ Cause ____

☐ Hypertension ☐ Cancer ☐ Cardiac ☐ Asthma ☐ Diabetes ☐ Alzheimer/Dementia

Paternal Grandfather Age alive/death ____ Cause ____

☐ Hypertension ☐ Cancer ☐ Cardiac ☐ Asthma ☐ Diabetes ☐ Alzheimer/Dementia

Paternal Grandmother Age alive/death ____ Cause ____

☐ Hypertension ☐ Cancer ☐ Cardiac ☐ Asthma ☐ Diabetes ☐ Alzheimer/Dementia

Maternal Grandfather Age alive/death ____ Cause ____

☐ Hypertension ☐ Cancer ☐ Cardiac ☐ Asthma ☐ Diabetes ☐ Alzheimer/Dementia

Maternal Grandmother Age alive/death ____ Cause ____

☐ Hypertension ☐ Cancer ☐ Cardiac ☐ Asthma ☐ Diabetes ☐ Alzheimer/Dementia

Other diseases ____

11 TOBACCO

☐ Never ☐ Current ☐ Former Year quit ____ Cigarettes/day ____

Time to first cigarette after waking ____ Interest in quitting ____

12 ALCOHOL & OTHER

☐ Alcohol in past year - Yes ☐ No

How often _____ Typical drinks/day _____

6+ drinks on one occasion - frequency _____

☐ Feeling down/depressed/hopeless - Yes ☐ No

☐ Little interest/pleasure in doing things - Yes ☐ No

☐ Recreational drugs - No ☐ Yes _____

Caffeine daily _____

13 REVIEW OF SYMPTOMS - CHECK ANY THAT APPLY

General:

☐ Fever/chills ☐ Malaise ☐ Fatigue ☐ Night sweats ☐ Headache ☐ Weight change

Eyes:

☐ Change in vision ☐ Blurring ☐ Double vision ☐ Pain ☐ Last eye exam

Ears:

☐ Hearing loss ☐ Pain ☐ Discharge ☐ Ringing

Nose:

☐ Loss of smell ☐ Obstruction

Throat:

☐ Hoarseness ☐ Frequent sore throat ☐ Sore/bleeding gums ☐ Toothaches ☐ Change in taste

Dentures:

☐ Upper ☐ Lower ☐ Full ☐ Partial

Endocrine:

☐ Thyroid enlargement ☐ Pain ☐ Tenderness ☐ Weight change ☐ Heat/cold intolerance ☐ Excessive thirst

Respiratory:

- ☐ Pain
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Sputum production
- ☐ Coughing blood
- ☐ Exposure to TB
- ☐ Last chest X-ray

Cardiac:

- ☐ Chest pain
- ☐ Palpitations
- ☐ Ankle swelling
- ☐ Leg cramps
- ☐ High blood pressure
- ☐ Other heart problems
- ☐ Last EKG
- ☐ Other heart tests

Gastrointestinal:

- ☐ Change in appetite
- ☐ Food intolerance
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Hernia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black/bloody stools
- ☐ Gallstones
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Jaundice

Hematology:

- ☐ Anemia
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Transfusions

Female:

- ☐ Breast lumps
- ☐ Breast pain
- ☐ Discharge from breast

Menstruation:

- ☐ Heavy
- ☐ Irregular
- ☐ Missed menses
- ☐ Painful menses
- ☐ Bleeding between periods
- ☐ Vaginal discharge
- ☐ Hot flashes
- ☐ Painful intercourse
- ☐ Infertility
- ☐ Fibroids
- ☐ Ovarian cysts
- ☐ Endometriosis

Male:

☐ Discharge from p☐s ☐ Ejaculation prob☐n ☐ Genital pain ☐ Impotence ☐ Lumps in testic☐ ☐ Poor libido

☐ Prostate enlargen☐t ☐ Prostate infecti☐ ☐ Other prostate problem

Lymphatic:

☐ Swollen lymph no☐s ☐ Pain

Urinary:

☐ Kidney/bladder sto☐s ☐ Urinary tract infec☐n ☐ Blood in urine ☐ Painful urinatio☐ ☐ Frequency ☐ Dribbling

☐ Decrease in force of stream

Musculoskeletal:

☐ Back pain ☐ Joint pain ☐ Leg pain ☐ Swelling in join☐ ☐ Muscle spasm ☐ TMJ problems ☐ Weakness

☐ Cramps

Skin:

☐ Rash ☐ Eruptions ☐ Itching ☐ Color change ☐ Abnormal hair/nail growth

Mental:

☐ Stroke ☐ Paralysis ☐ Depression ☐ Crying spells ☐ Memory loss ☐ Loss of balance ☐ Suicidal thoughts

14 ADDITIONAL MEDICATIONS OR INFORMATION FOR YOUR DOCTOR