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

PATIENT NAME:_____ DOS: _____

Date of birth:_____ Age at this visit: _____

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/Immunosuppresive 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:

___ ___ Bleeding disorder
___ ___ Blood clots in lungs or legs
___ ___ Cancer
Type: _____
___ ___ Clotting disorder
___ ___ Previous transfusions
___ ___ Anemia

RENAL/GU:

___ ___ Kidney disease impairment
___ ___ Dialysis
___ ___ Kidney stones
___ ___ Prostate problems
___ ___ Frequent urinary tract infection

MUSCULOSKELETAL:

Yes No

___ ___ Previous fractures
___ ___ Previous muscle/tendon injury
___ ___ Osteoarthritis
___ ___ Rheumatoid arthritis
___ ___ Scleroderma
___ ___ Fibromyalgia
___ ___ Lupus
___ ___ Scoliosis

INTEGUMENTARY/SKIN:

___ ___ Eczema
___ ___ Psoriasis
___ ___ Tattoos
___ ___ Body Piercing

METABOLIC/ENDOCRINE:

___ ___ Irregular menstrual cycle
___ ___ Diabetes - ___Insulin ___Non-insuln
___ ___ Hypoglycemia
___ ___ Gout
___ ___ Hypothyroidism
___ ___ Hyperthyroidism
___ ___ Hyperparathyroidism
___ ___ Hashimotos goiter
___ ___ Paget's disease

PSYCHOLOGIC:

___ ___ Depression
___ ___ Anxiety disorder

EYES/EARS:

Yes No

___ ___ Deafness Rt Lt
___ ___ Hard of hearing/hearing aid
___ ___ Cataracts
___ ___ Glaucoma
___ ___ Blindness
___ ___ Glasses
___ ___ Contacts

NEUROLOGIC:

___ ___ Alzheimer's disease
___ ___ Parkinson's disease
___ ___ Stroke
___ ___ Seizure disorder

PULMONARY:

___ ___ Asthma
___ ___ Bronchitis
___ ___ Emphysema
___ ___ TB or exposure

GASTROENTEROLOGIC:

___ ___ Gastric reflux
___ ___ Ulcer disease
___ ___ Irritable bowel syndrome
___ ___ Crohn's or ulcerative colitis
___ ___ Hiatal hernia
___ ___ Cirrhosis
___ ___ Hepatitis A B C

Other _____

REVIEW OF SYSTEMS:

Are you experiencing any of the following? CHECK YES or NO TO EACH ITEM

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Increased energy	___	___	Recent onset of high blood pressure	___	___	Tingling	___	___	Blurred vision
___	___	Decreased energy	___	___	Cold extremities	___	___	Muscle pain with any activity or rest	___	___	Shortness of breath
___	___	Recent weight loss	___	___	Joint swelling	___	___	Back pain	___	___	Chronic cough
___	___	Recent weight gain	___	___	Joint pain	___	___	Rashes	___	___	Problems breathing
___	___	Generalized weakness	___	___	Numbness	___	___	Headaches	___	___	Diarrhea
___	___	Fever for unknown reason	___	___	Burning on urination	___	___	Increased urinary frequency	___	___	Constipation
___	___	Poor bladder control							___	___	Depression

Other:

_____

_____

PATIENT NAME:_____ DOB:_____ DOS:_____

Family Physician/Primary Care Provider: _____
Specialist:_____
_____

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 complication ( ) Blood clots in lungs or legs
( ) Patient adopted – no history available ( ) 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 currently use: 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 performed	Facility (i.e., Memorial, Chattanooga Outpatient Center)	Films/Reports
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY PHYSICIAN/PRIMARY CARE PROVIDER: _____
REFERRING PHYSICIAN: _____
SPECIALIST:_____
_____

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: _____