PATIENT DATABASE

Name ____ SS# ______________________ Date______________________
(First, Middle initial and last name)

Address____ Date of Birth______________________Age____________

City_______________________________________State___________Zip___________________

Home Phone____ Work Phone____________________________________

Spouse/Significant Other's Name_________________________________ Work Phone__________________________

Contact person_______________________________________ Phone Number________________________________
(*Other than spouse or significant other)* Relationship to you______________________________

PERSONAL HISTORY: ☐ Retired ☐ Disabled ☐ Working Full Time ☐ Working Part Time

Employer____**Occupation**____________________________________
Highest Education (circle one) ________ Grade, High School, College Graduate School (type) ______________________
Other Education ____
Primary Language _________________________________ Other languages you speak ____________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Number of children**: ____________
Religious Preference: ☐ Yes ☐ No Type: ________________________________
Alcohol Use: ☐ Yes: How much per day? _________________________________ ☐ **Never**

Cigarette Smoking?: ☐ Yes: _______ppd How long?_________ ☐ **Quit: When**?_______ ☐ **Never Smoked**
Cigar Smoking?: ☐ Yes ☐ No **Pipe Smoking?**: ☐ Yes ☐ No **Other tobacco use**: ☐ Chewing ☐ Snuff
Exposure to second hand smoke? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No: Describe Exercise: ____
Present diet ________________________________ **Do you have pets?** ☐ Yes ☐ No Type _______________

Have you missed doses of medication due to inability to purchase them? ☐ Yes ☐ No
Does insurance, Medicare or Medicaid assist you in cost of prescriptions? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No If no, who lives with you?____
Do you need assistance with normal activities at home? (Dressing, bathing, feeding) ☐ Yes ☐ No
Does your family live close by? ☐ Yes ☐ No **Does your family help you with your care**? ☐ Yes ☐ No
Do you have a living will (Advanced Directive)? ☐ Yes ☐ No
Do you drive a car? ☐ Yes ☐ No **If no, how is transportation provided**? ________________________________
Have you had any accident, traffic violations or close calls in the last two years? ☐ Yes ☐ No

Herbal Supplements:

☐ Gingko ☐ St. John's Wort ☐ Echinacea ☐ Dietary Supplements_________________________________
Other __________________________________ ☐ Caffeine/Amount/day________________________________

Illicit Street Drugs:

☐ Marijuana ☐ Cocaine ☐ Other ______________________________

Immunization: ☐ MMR (Measles, mumps and rubella) ☐ DPT (Diphtherial, Pertussis, Tetanus) ☐ OPV (Polio) ☐ Hepatitis A

☐ Hepatitis B ☐ Meningitis ☐ Pneumovax __________ (year) ☐ Tetanus Booster ________ (year) ☐ Zostavax __________ (year)

☐ DPT Booser (Tdap) __________ (year)

History of environmental exposure:

☐ Asbestos ☐ Lead (i.e. old paint) ☐ Diesel Fuel ☐ Other______________________

☐ Any other dust, fumes, gases or chemicals which irritate your nose, mouth, throat, and/or lungs?

Please list all allergies or abnormal reactions to x-ray dye, shellfish or other food, anesthesia, latex, tape, bee or insect stings/bites or other drugs that cause allergies or abnormal reactions and what symptoms you have with this allergy/abnormal reaction below:

____

____

Past Medical History:

Please list any major illnesses you have or have had along with year diagnosed:

☐ Atrial Fibrillation______________
☐ **Anemia** Iron Deficiency _________
☐ **Anemia** Other _________________
☐ **Anemia** Pernicious ______________
☐ Angina______________________
☐ Aortic aneurysm_______________
☐ Asthma_____________________
☐ Attention Deficit Disorder ________
☐ Bipolar Disorder_______________
☐ Blood clot in legs and/or lungs______
☐ Celiac Disease (Sprue)___________
☐ Chronic Kidney Disease__________ (no dialysis)
☐ Chronic Bronchitis______________
☐ COPD______________________
☐ Dementia____________________
☐ Depression___________________
☐ Diabetes_____________________
☐ Eating Disorder_______________
☐ Eczema _____________________
☐ Emphysema__________________
☐ End stage kidney disease__________ (on dialysis)
☐ Fibromyalgia___________________
☐ Glaucoma______________________
☐ Goiter_________________________
☐ Heart attack____________________
☐ Heart failure____________________
☐ Hepatitis A_________________ ____
☐ Hepatitis B______________________
☐ Hepatitis C______________________
☐ Herpes Simplex_____________ ____
☐ High blood pressure_______________
☐ High cholesterol and/or Triglycerides____
☐ HIV/AIDS________________ _____
☐ Inner Ear dizziness/vertigo__________
☐ Irritable bowel syndrome ______ _____
☐ Kidney stones____________________
☐ Lupus_________________________
☐ Melanoma______________________
☐ Migraines Headaches_____________
☐ Mononucleosis ___________________
☐ More than one miscarriage__________
☐ Nasal Polyps_____________________
☐ Obsessive Compulsive Disorder______
☐ Osteoarthritis_____________________
☐ Osteoporosis_____________________
☐ Panic disorder____________________
☐ Peptic ulcer disease_______________
☐ Peripheral neuropathy____________
☐ Peripheral arterial disease (PAD)___
☐ Psoriasis_________________________
☐ Restless Leg Syndrome___________
☐ Reflux (GERD)_________________
☐ Rheumatoid arthritis_____________
☐ Seizures_______________________
☐ Shingles (Herpes Zoster)__________
☐ Skin cancer____________________
☐ Sleep apnea____________________
☐ Stroke________________________
☐ Thyroid disease (overactive)______
☐ Thyroid disease (underactive)_____
☐ Thyroid nodules________________
☐ Tuberculosis___________________
☐ Varicose veins_________________

☐ Cancer, type____________________________________
☐ Other ____

Please list any past surgeries (Dates):

Adenoids____________________ Heart Bypass____________________ Neck (cervical spine)______________
Appendix____________________ Aortic Heart Valve________________ Ovaries (one or both) – R_____L____
Bladder_____________________ Mitral Heart Valve________________ Pacemaker ______________________
Bypass Artery in legs – R__L___ Hemorrhoids____________________ Shoulder - R_________L__________
Carotid artery – R_____ L______ Hernia R_________L____________ Sinuses________________________
Cataracts (one or both)-R___L___Hip - R________L______________ Tonsils__________________________
C-Section(s)_________________ Implantable defibrillator__________ Uterus__________________________
Gallbladder__________________Knee – R__________L____________ Wrist – R_________L____________
Gastric Bypass________________ Low back______________________
Transplant: Kidney ___ Corneal ___ Heart ___ Liver ___ Pancreas ___ Other _______________
Cosmetic____
Other Surgeries: ____
Biopsies: Breast _______ Prostate ________ Cervix_______ Thyroid Nodules________ Other ______________________
Fractures Hip – R_____L_____ Spine _________________ Wrist – R_____L______ Ribs___________
Other ____

Please list any other hospitalizations (where, reason, and date):

____
____
____
____

Are you being followed by Home Health or Hospice? ☐ Yes ☐ No
Name of Agency ____

Medical Equipment: ☐ glucometer ☐ nebulizer ☐ oxygen ☐ BP cuff ☐ cane ☐ walker ☐ Insulin Pump
☐ manual wheelchair ☐ hospital bed ☐ bedside commode ☐ Electric wheelchair ☐ Scooter ☐ other________________________
Who provides your diabetes testing supplies? ____
Who provides your nebulizer supplies and/or oxygen? ____

FAMILY HISTORY: ☐ **Unknown**

☐ High blood pressure ☐ Elevated cholesterol ☐ Stroke

☐ Blood clot in leg before the age of 50 for father, mother, brother and/or sister

☐ Blood clot(s) in the lungs before the age of 50 for father, mother, brother and/or sister

☐ Aortic aneurysm ☐ Sickle Cell Anemia ☐ Other Anemia

☐ Osteoporosis ☐ Diabetes ☐ Asthma ☐ Depression ☐ Bipolar/Manic Depression

☐ Premature Heart attack (before age 55 for father and/or brother or before 65 for mother and/or sister)

☐ Cancer (circle type) breast, ovary, prostate or colon, melanoma or other ____________________________

☐ Other Illness (es) ____

Constitutional
- ❑ Recent weight gain
- ❑ Recent weight loss
- ❑ Loss of height
- ❑ Fatigue
- ❑ Night sweats
- ❑ Hot flashes
- ❑ Loss of appetite
- ❑ Fever
- ❑ Chills
- ❑ Unable to do strenuous activities

Eyes
- ❑ Change in vision
- ❑ Loss of vision
- ❑ Glasses
- ❑ Contacts
- ❑ Dry eyes
- ❑ Discharge from eye(s)
- ❑ Excessive watering of eye(s)
- ❑ Yellow eye(s)
- ❑ Itching of eye(s)
- ❑ Double vision

ENT/Mouth
- ❑ Hearing loss
- ❑ Hearing aid
- ❑ Earache
- ❑ Ringing in ear(s)
- ❑ Drainage from ear(s)
- ❑ Teeth in poor repair
- ❑ Dentures
- ❑ Bridges
- ❑ Partial Plate
- ❑ Mainly breathes through the mouth
- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Pain in gums
- ❑ Mouth sores
- ❑ Sore tongue
- ❑ Difficulty with taste
- ❑ Hoarseness
- ❑ Frequent sore throat
- ❑ Frequent nose bleeds
- ❑ Nasal congestion
- ❑ Nasal drainage
- ❑ Difficulty breathing through the nose
- ❑ Sores in nose
- ❑ Snoring
- ❑ Sneezing
- ❑ Itching of the nose/throat
- ❑ Difficulty with smell

Health Maintenance

Last Pap______________	☐ Never
Last Mammogram____________	☐ Never
Last Rectal Exam_____________	☐ Never
Last Colonoscopy_____________	☐ Never
Last PSA_____________________	☐ Never

Neurological
- ❑ Numbness of hand(s)
- ❑ Numbness of foot/feet
- ❑ Shaking/tremor of arms, hands, feet or legs
- ❑ Dizzy/lightheaded
- ❑ Passing out/fainting
- ❑ Memory loss
- ❑ Confusion
- ❑ Episodes of getting lost while driving
- ❑ Trouble with speaking
- ❑ Difficulty walking/balance
- ❑ Headaches
- ❑ At least 5 headaches lasting 4-72 hours
- ❑ Headaches on one side of head
- ❑ Pulsating quality to headaches
- ❑ Headache sever enough to prohibit daily activity
- ❑ Headache aggravated by routine physical activity
- ❑ Headache with nausea/vomiting
- ❑ Sensitivity to light or sound with headache
- ❑ Sees spots or light flashes before, during or after headache
- ❑ Excess drowsiness/sleepiness during the day
- ❑ Difficulty getting out of chair or off commode

Endocrine
- ❑ Hair loss
- ❑ Excessive hair
- ❑ Increased thirst
- ❑ Darkening of the skin

Breasts
- ❑ Lump
- ❑ Pain
- ❑ Change in nipple(s)
- ❑ Discharge from nipple(s)
- ❑ Bleeding from nipple(s)

Skin
- ❑ Rash
- ❑ Change in mole
- ❑ Itching
- ❑ Sore(s) that will not heal
- ❑ Dry skin
- ❑ Yellow skin
- ❑ Hives
- ❑ Abnormal loss of hair
- ❑ Abnormal fingernail(s)
- ❑ Abnormal toenail(s)
- ❑ Tattoo(s)
- ❑ Piercing(s)

Respiratory
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Dry cough
- ❑ Cough productive white/clear sputum
- ❑ Cough productive of colored sputum
- ❑ Coughing up blood
- ❑ Stops breathing while sleeping
- ❑ Snoring

Gastrointestinal
- ❑ Pain in throat when swallowing
- ❑ Food sticking in throat or chest
- ❑ Difficulty swallowing
- ❑ Coughing while eating
- ❑ Heartburn/Indigestion
- ❑ Nausea/Vomiting
- ❑ Stomach pains
- ❑ Excessive gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Blood in stool
- ❑ Incontinence of stool
- ❑ Mucous in stool
- ❑ Black stools
- ❑ Light colored stools

Cardiovascular
- ❑ Chest pain/tightness
- ❑ Irregular heartbeats/palpitations
- ❑ Awaking at night short of breath
- ❑ Sleeping on more than one pillow due to shortness of breath
- ❑ Swelling of feet/legs
- ❑ Pain in legs with walking

Genitourinary
- ❑ Difficulty urinating
- ❑ Pain with urination
- ❑ Frequent urination (more than 8 times in 24 hours)
- ❑ Increased urination only at night (more than 2 times a night)
- ❑ Excessive urination
- ❑ Sudden incontinence of urine
- ❑ Incontinence of urine with cough, sneezing, laughing, etc.
- ❑ Sudden excessive urge to urinate
- ❑ Decreased urinary stream/dribbling
- ❑ Blood in urine
- ❑ Sensation bladder not emptying completely
- ❑ Loss of interest in sex
- ❑ Decreased amount of urine
- ❑ Dark urine

Male
- ❑ Sore(s) on penis
- ❑ Erectile dysfunction
- ❑ Pain in testicle(s)
- ❑ Growth on testicle(s)
- ❑ Premature ejaculation

Female
- ❑ Abnormal vaginal bleeding between periods
- ❑ Excessive bleeding with periods
- ❑ Vaginal itching
- ❑ Vaginal discharge
- ❑ Pain or problems during sexual intercourse
- ❑ Forced to have sexual intercourse
- ❑ Menstrual pain or problems

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Loss of interest in things you used to enjoy doing
- ❑ Nightmares
- ❑ Difficulty sleeping
- ❑ Manic episodes
- ❑ Panic attacks
- ❑ Hearing voices and/or seeing things that are not there

Allergic/Immunology

- ❑ Recurrent infections
- ❑ Chronic steroid (Prednisone) use

Hematologic/Lymphatic

- ❑ Easy bruising/bleeding
- ❑ Swollen/painful lymph nodes
- ❑ Transfusion(s)

Musculoskeletal

- ❑ Pain in the joint(s), which one(s)____
- ❑ Swelling of joint(s), which one(s)____
- ❑ Stiffness of joint(s), which ones____
- ❑ Deformity of joint(s), which one(s)____
- ❑ Pain in muscle(s), which one(s)____
- ❑ Weakness in muscle(s), which one(s)____
- ❑ Back pain
- ❑ Frequent falls
- ❑ Problem with coordination
- ❑ Pain in arm(s)
- ❑ Pain in leg(s)

Screen for Abuse/Neglect

Have you been emotionally or physically abused by your partner or someone important to you?
□ Yes □ No

Have you ever been hit, slapped, kicked or otherwise physically hurt by someone? □ Yes □ No

Has anyone forced you to have sexual activities?
□ Yes □ No

Are you afraid of your partner or someone important to you? □ Yes □ No

Are you now/or have you ever been left alone without food/water? □ Yes □ No

Alcohol use

Have you thought you should cut down on your drinking? □ Yes □ No

Has anyone complained about your drinking?
□ Yes □ No

Have you felt guilty or upset about your drinking?
□ Yes □ No

Was there ever a single day when you had five or more drinks of beer, wine or liquor?
□ Yes □ No

I have completed this form as thoroughly as possible

________________________	____________________
Patients Signature	Date
Signature of person completing this form	Date
Signature of physician/PA/NP reviewing form	Date

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