Patient History Form

Name
Date
Age

Problems to discuss with Physician/NP today
1)  
2)  
3)  
4)  

Medical Problems (check all conditions you have & approximate date on onset)
Elevated Blood Pressure Asthma
Heart Disease Diabetes
High Cholesterol Cancer
Blood Disorder Thyroid disorder
Other

Past Surgeries/Procedures
1)  
2)  
3)  
4)  

Family History (Please stipulate relationship to you by listing
Mother, Father, Maternal/Paternal Grandmother,
Maternal/Paternal Grandfather, Sister, Brother)
Elevated Blood Pressure N Y
Asthma N Y
Heart Disease N Y
Diabetes N Y
High Cholesterol N Y
Cancer N Y
Blood Disorder N Y
Thyroid Disorder N Y
Other
Allergies:

Current Medications:
1) ______________________________________________________________________
2) ______________________________________________________________________
3) ______________________________________________________________________
4) ______________________________________________________________________
5) ______________________________________________________________________
6) ______________________________________________________________________
7) ______________________________________________________________________
8) ______________________________________________________________________

Social History
Marital Status: Single___ Married___ Divorced___ Widowed___

Occupation ______________________________________________________________________

Tobacco Use: Y N How much per day/month ______________________________________________________________________
Drink Alcohol: Y N How much per day/month ______________________________________________________________________
How much caffeinated soda do you drink per day ______________________________________________________________________
How much caffeinated coffee do you drink per day ______________________________________________________________________
How much caffeinated tea do you drink per day ______________________________________________________________________

How many times per week do you exercise____ Duration____
Type of exercise walking___ running___ yoga___ weights___
Other ______________________________________________________________________