Patient History Form

Name______________________________Age_________
Date_________________

Problems to discuss with Physician/NP today

1)_______________________3)_______________________

2)_______________________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)______________________3)__________________________
2)______________________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)_____________________ 5)_______________________
2)_____________________ 6)_______________________
3)_____________________ 7)_______________________
4)_____________________ 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____