

PATIENT HISTORY / ASSESSMENT FORM
Please answer all questions to the best of your ability.

Practitioner: _____ Date: _____

Patient Name: _____ Date of Birth: _____ Sex: M F
 Address: _____ Phone: (hm) _____ (wk) _____
 City/State/Zip: _____ Referring Physician: _____
 Current Employer: _____ Current Occupation: _____
 Marital Status: Single Married Widowed Divorced Separated
Reason for visit today: _____

ALLERGIES: List any allergies you have to medications, foods, or environment _____

Do you have a **LATEX** sensitivity or allergy? Yes No

Following a medical, surgical or dental procedure, have you ever had any unexplained itching, hives, swelling, or anaphylactic reaction? Yes No

Have you had symptoms such as sneezing, coughing, wheezing, rash or hives when handling rubber products, balloons, latex gloves or Band-Aid's? Yes No

CURRENT MEDICATIONS: Please list all current medication (and dosage, if known). Include over the counter drugs, herbal remedies, nutritional supplements, etc. _____

HISTORY: Please indicate if you have previously or are currently experiencing any of the following problems:

Condition	Past Problem	Current Problem	Explain any current symptoms or treatment
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Anticoagulant therapy/ (blood thinners)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lung trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Acute infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Thyroid trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Kidney trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bleeding tendencies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Skin Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

If yes, specify: _____

Past Surgeries, including date: _____

Have you had any reaction to anesthesia? Yes No

Pt. Name: _____ **Pt #:** _____ **DOB:** _____

HISTORY CONTINUED:

Indicate if you have had the following, or mark as NA (not applicable)

Flu vaccine: Yes No Date: _____ Last Menstrual Period: Date: _____ NA
Tetanus shot: Yes No Date: _____ Mammogram: Date: _____ NA
Pneumovax: Yes No Date: _____ Chest x-ray: Date: _____ NA

Do you use tobacco products? Yes No Quit (when?) _____
Product: _____ Amount: _____ How Long: _____

Do you drink alcohol: Yes No Quit (when?) _____
Product: _____ Amount: _____ How Long: _____

Do you use street/other illicit drugs: Yes No Type/Quantity: _____

Do you use seat belts: ----- Yes No

Do you have children, do you use car safety seats: ----- Yes No

Within the last year, have you been hit, slapped, kicked or otherwise physically injured by someone Yes No

List any hazards associated with employment: _____

Any other problems you have not previously listed: _____

FAMILY HISTORY:

Relation	Age	General Health/Diseases	If deceased, at what age and cause of death if known
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
	_____	_____	_____
Sister(s)	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Other relative (s) with significant/similar problems to your complaint? _____

Is the person completing this form the patient? Yes No

If no, state name and relationship to patient _____

PHYSICIAN REVIEW:

INITIALS

DATE

Pt. Name: _____ **Pt.#:** _____ **DOB:** _____