REKINDLE Family Medicine

PATIENT HISTORY FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES			
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	**DATE OF BIRTH**	**SEX** ❑ MALE ❑ FEMALE	**DATE**
WHAT ARE YOUR MAIN CONCERNS FOR TODAY'S VISIT?			
HOME SITUATION ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Domestic Partnership	**DO YOU HAVE A LIVING WILL?** ❑ YES ❑ NO **DO YOU HAVE A POWER OF ATTORNEY?** ❑ YES ❑ NO ❑ **IF YES, WHO?** _____	**EMPLOYMENT STATUS** ❑ Full time ❑ Part time ❑ Homemaker ❑ Retired ❑ Disabled	**TYPE OF OCCUPATION**
Children's Names _____ _____ _____ _____	**MEDICATION ALLERGIES** _____ _____ _____ _____		**OTHER ALLERGIES** _____ _____ _____ _____

HABITS				
SMOKING STATUS: ❑ Non-Smoker	❑ Current smoker _____ packs per day _____ years	❑ Past smoker _____ packs per day _____ years	**HAVE YOU HAD A HISTORY OF DRUG USE IN THE PAST** ❑ YES ❑ NO	**DO YOU WEAR A SEATBELT ALL THE TIME?** ❑ YES ❑ NO
ALCOHOL USE: ❑ None	❑ Current alcohol use _____ per day	❑ Prior alcohol use _____ per day	**DO YOUR FRIENDS OR FAMILY WORRY ABOUT YOUR ALCOHOL INTAKE?** ❑ YES ❑ NO	**HAVE YOU HAD A TRAFFIC VIOLATION IN THE LAST 2 YEARS?** ❑ YES ❑ NO
HOW MANY CAFFEINATED DRINKS PER DAY? ❑ NONE ❑ 1-2 ❑ 3-5	**RECENT WEIGHT LOSS OR GAIN?** ❑ YES ❑ NO **INTENTIONAL?** ❑ YES ❑ NO	**ARE YOU ON A PARTICULAR DIET?** _____	**HOW MANY TIMES A WEEK DO YOU EXERCISE?** ❑ 0-2 ❑ 3-5 ❑ 6-7	**ARE YOU CONCERNED ABOUT YOUR SALT INTAKE?** ❑ YES ❑ NO

PERSONAL MEDICAL HISTORY		
LIST ALL THE CURRENT CONDITIONS THAT YOU ARE BEING TREATED FOR (USE BACK IF NECESSARY)	**MEDICATIONS TAKEN (USE BACK IF NECESSARY)**	**DOSE**
1		
2		
3		
4		
5		
6		
ANY OVER THE COUNTER/HERBAL SUPPLEMENTS?		

PAST MEDICAL HISTORY		
LIST ALL THE PAST CONDITIONS THAT YOU WERE BEING TREATED FOR	**MEDICATIONS TAKEN**	**DOSE**
1		
2		
3		
4		

SURGICAL HISTORY			
TYPE OF SURGERY (USE BACK IF NECESSARY)	**WHERE PERFORMED**	**DOCTOR**	**DATE**
1			
2			
3			
4			
5			
6			

PSYCHOSOCIAL	
ANY RECENT STRESSORS (please describe)	
SUPPORT SYSTEM - Who do you look to for support? Friends, family or other?	
FINANCIAL - How do you consider your financial situation? What challenges do you have with money?	
SPIRITUAL - What aspects of spiritual practice do you find most helpful? (prayer, church, meditation, reading religious texts)	
ANY PERSONAL OR OTHER ISSUES YOU WANT TO DISCUSS?	

FAMILY HISTORY

Place an "X" in the boxes to identify diseases your relatives have been treated for

Illness/Condition	Family Member							
	grandparents	**father**	**mother**	**brother**	**sister**	**son**	**daughter**	**other**
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Thyroid disease								
Other								

REVIEW OF SYSTEMS (CHECK BOX IF POSITIVE)

Gastrointestinal
- ▫ poor appetite
- ▫ abdominal pain
- ▫ indigestion or acid reflux
- ▫ trouble swallowing
- ▫ diarrhea
- ▫ constipation
- ▫ change in bowel habits
- ▫ nausea or vomiting
- ▫ rectal bleeding or blood in stools
- ▫ history of liver disease or abnormal liver tests
- ▫ date of last colonoscopy _____

Cardiovascular
- ▫ chest pain
- ▫ history of angina or heart attack
- ▫ history of high blood pressure
- ▫ history of irregular beat
- ▫ history of poor circulation

Pulmonary/lungs
- ▫ shortness of breath
- ▫ persistent cough
- ▫ coughing up blood
- ▫ asthma or wheezing

Muscle/joint/bone
- ▫ swelling of upper or lower extremities
- ▫ weakness of upper or lower extremities
- ▫ back or hip pain
- ▫ legs or foot problems
- ▫ neck or shoulders pain

Neurologic
- ▫ history of stroke
- ▫ blackouts or loss of consciousness
- ▫ numbness or tingling
- ▫ vision changes
- ▫ headaches
- ▫ memory loss

General
- ▫ weight gain/loss of 10+ lbs during last 6 months
- ▫ poor sleep
- ▫ fever
- ▫ headache
- ▫ depression
- ▫ cold or heat intolerance
- ▫ difficulty sleeping or getting to sleep

Eyes, ears, nose, throat
- ▫ blurred vision
- ▫ other change in vision
- ▫ history of glaucoma or cataracts
- ▫ loss of hearing
- ▫ ringing in ears
- ▫ sinus problems
- ▫ hoarseness

Genitourinary
- ▫ frequent or painful urination
- ▫ blood in urine

Skin
- ▫ itching
- ▫ easy bruising
- ▫ change in moles

Endocrine
- ▫ history of diabetes
- ▫ history of thyroid disease
- ▫ change in tolerance to hot or cold weather
- ▫ excessive thirst

Women only
- ▫ abnormal Pap smear
- ▫ bleeding between periods
- ▫ date of last mammogram _____

Men only
- ▫ change in urine stream
- ▫ nightly awakenings to urinate
- ▫ sexual function concerns