



SUNSET
medical practice group, p.c.

PATIENT HISTORY FORM

Today's Date: _____

Name: _____ Date of Birth: _____

Occupation: _____ Date of last physical exam: _____

Please list the names of other providers from whom you have received care in the past year (including physicians, chiropractors, counselors, acupuncturists, naturopaths, or psychiatrists):

What is the main reason for your visit today? (Explain specific symptoms, how they started and what happened).

PAST MEDICAL HISTORY:

Do you have, or have you had in the past, any of the following conditions: (please circle)

- | | | |
|--------------------|---------------------|----------------------|
| Anxiety | Heart Disease | Rheumatoid Arthritis |
| Asthma | Hepatitis | Seizure Disorder |
| Depression | High Blood Pressure | Stroke |
| Diabetes | High Cholesterol | Thyroid Disease |
| GERD | Kidney Disease | Tuberculosis |
| Heart Attack | Osteoporosis | STD |
| Cancer- type _____ | | Other: _____ |

Please list any prior injuries and the date of injury: _____

SURGICAL HISTORY: Please list any surgeries you have had with the dates performed:

MEDICATIONS:

Please list any prescription or over the counter medications you take (including vitamins) and the dose:

ALLERGIES:

Have you ever had a reaction to any medication? If so, which med and what happened? _____

Are you on a special diet? If yes, please explain.

FAMILY HISTORY:

Are there any illnesses such as cancer, diabetes, heart disease, or depression that run in your family? Y N

If so, what are they? _____

Health status of your family:

Relationship:	Living:	Age:	Significant Health Problems:
Mother	Y N	_____	_____
Father	Y N	_____	_____
Sibling	Y N	_____	_____
Sibling	Y N	_____	_____
Sibling	Y N	_____	_____
Paternal Grandfather	Y N	_____	_____
Paternal Grandmother	Y N	_____	_____
Maternal Grandfather	Y N	_____	_____
Maternal Grandmother	Y N	_____	_____
Children	Y N	_____	_____
_____	Y N	_____	_____
_____	Y N	_____	_____

Do You:

Currently smoke tobacco? Y N If yes, how much? _____ How long? _____

Have you been a smoker in the past? Y N

If yes, how long? _____ packs/day? _____ last quit date? _____

Drink alcohol? Y N If yes, how much? _____

Drink caffeinated beverages? Y N If yes, how much? _____

Use any recreational or "street drugs" (including marijuana, cocaine, LSD, ecstasy, methamphetamine) Y N

If yes, what type: _____ how much? _____

Ever inject drugs? Y N If yes, how much? _____

Wear seatbelts? Y N If yes, how often? _____

Are you sexually active? Y N If so, with men? _____ with women? _____

Have an HIV concern? Y N If yes, why? _____

Exercise regularly? Y N If yes, what type and how often? _____

Own firearms? Y N If so, are they in your home? _____

Travel outside the U.S.? Y N If so, where? _____

Where were you born? _____

Have You:

Had a tetanus shot in the last 10 years? Y N If so, when? _____

Ever had a pneumonia vaccine? Y N If so, when? _____

Ever had a flu shot? Y N If so, when? _____

Been tested for colon cancer? Y N If so, when? _____

WOMEN:

Date of last pap smear? _____ Last Mammogram? _____

Date of last menstrual period? _____ Is your period predictable? _____

Birth control method: _____

Number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____

Review of Systems:

Please circle any of these that apply to you or write in any that are not listed.

General: fever, chills, night sweats, fatigue, weakness, weight loss, sleep disorder, anxiety, anger, sadness, poor concentration _____

Eyes: blurred vision, double vision, irritation, eye pain, vision loss, wear glasses or contacts _____

Date of last eye exam: _____

Ears, Nose, Throat: ear pain, popping, ringing in ears, decreased hearing, nasal congestion, nose bleeds, sore throat, hoarseness, snoring, wax in ears _____

Cardiovascular: chest pain, palpitations, light headedness, shortness of breath with walking, difficulty sleeping flat, heart disease, leg or ankle swelling _____

Respiratory: cough, shortness of breath at rest, excessive phlegm, bloody phlegm, wheezing, chest pain with a deep breath, asthma _____

Gastrointestinal: nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, blood in stool, blood in vomit, jaundice, gas, bloating, indigestion/heartburn, difficulty swallowing, ulcers, hernia _____

For Men: painful urination, blood in urine, penile discharge, urinary frequency, urinary hesitancy, abnormal urine stream, waking frequently to urinate, lose urine with cough or straining, testicular pain or swelling, difficulty achieving or maintaining erections, pain with ejaculation, premature ejaculation, history of sexually transmitted disease _____

For Women: vaginal discharge, lose urine with cough or straining, painful urination, blood in urine, urinary frequency, heavy cycles, irregular cycles, pain with menses, pain or bleeding with intercourse, history of abnormal pap smear, history of sexually transmitted disease _____

Muscles and Joints: back pain, joint pain, joint swelling, muscle cramps or pain, muscle weakness, arthritis, fractures, dislocations, sprains, cold or blue fingers and toes _____

Skin: rash, itching, dryness, moles, acne, flaky scalp, skin cancer _____

Neurologic: burning or tingling, seizures, tremors, dizziness, fainting spells, blurry vision, frequent falls, frequent headaches, difficulty walking, memory loss _____

Psychological: depression, anxiety, memory loss, phobias, confusion _____

Endocrine: cold intolerance, heat intolerance, excessive thirst, excessive urination, unusual weight change _____

Blood: abnormal bruising, abnormal bleeding, anemia, enlarged or swollen glands _____

Allergy: itching, hay fever, rashes _____

Physician Signature: _____ **Date:** _____

Yearly Review and Update:

Date: _____	Patient signature: _____	Provider signature: _____
Date: _____	Patient signature: _____	Provider signature: _____
Date: _____	Patient signature: _____	Provider signature: _____
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