Hawthorne Family Practice

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PATIENT HISTORY FORM

Patient's Name:_____DOB:_____ Date:_____

Briefly describe what bring you to the Doctor:_____
_____
_____

List all your Medications (including the dosage, frequency, and any Over the counter medications/supplements)

1._____ **6._____**

2._____ **7._____**

3._____ **8._____**

4._____ **9._____**

5._____ **10._____**

Medication Allergies

1._____Reaction_____

2._____Reaction_____

3._____Reaction_____

4._____Reaction_____

Past Medical History: Please Circle if you have had any of the following and the year diagnosed.

Diabetes:	**Yes**	**Thyroid**	**Yes**	**Psychiatric**	**Yes**	**T/B**	**Yes**
High blood Pressure	**Yes**	**Lung disease**	**Yes**	**Kidney Disease**	**Yes**	**Infertility**	**Yes**
Bleeding problems	**Yes**	**Anesthesia Problems**	**Yes**	**Heart Disease**	**Yes**	**Cancer**	**Yes**
Liver Problems	**Yes**	**Urinary infections**	**Yes**	**Seizure**	**Yes**	**Type of cancer_____**	

Females: Past Gynecological History 1. Last Menstrual Period_____ 2. # of pregnancies_____
3. Live births_____ Do you believe you are pregnant? Yes No Unknown

Past Surgical History: Please list all your surgeries and the date of the surgery

1._____ **5_____**

2._____ **6._____**

3._____ **7._____**

4._____ **8._____**

Social History

□ Single □ Married □ Divorced □ Widowed

Occupation_____

Do you or have you ever

Used tobacco? Yes No Quit
If yes, How Much?_____
If Quit, When? _____

Alcohol Yes No Quit
If yes, How Much?_____
If Quit, When? _____

Drugs Yes No Quit
If yes, How Much?_____
If Quit, When? _____

Turn page

Family Medical History: **Disease or cause of death**

			Father	**Age**	**Living**	**Deceased**_____
			Mother	**Age**	**Living**	**Deceased**_____
Brother	**Age**	**Living**	**Deceased**_____			
Brother	**Age**	**Living**	**Deceased**_____			
			Sister	**Age**	**Living**	**Deceased**_____
Sister	**Age**	**Living**	**Deceased**_____			
			Sister	**Age**	**Living**	**Deceased**_____

Circle if any member of your family has ever had any of the following:

Diabetes:	**Yes**	**Thyroid**	**Yes**	**Psychiatric**	**Yes**	**T/B**	**Yes**
High blood Pressure	**Yes**	**Lung disease**	**Yes**	**Kidney Disease**	**Yes**	**Infertility**	**Yes**
Bleeding problems	**Yes**	**Anesthesia Problems**	**Yes**	**Heart Disease**	**Yes**	**Cancer**	**Yes**
Liver Problems	**Yes**	**Urinary infections**	**Yes**	**Seizure**	**Yes**		

Type of cancer _____

Review Of Systems:

Do You Now Or Have You Recently Had Problems With Any Of The Following?

(Please Circle Your Answer)

GI System:	Pain or burning with urination	Kidney stone	Frequency	Slow or small stream	Blood in urine
	Getting up at night to urinate	Leaking of urine	Urgency	Poor bladder emptying	Recurrent urine infections
	Abnormal vaginal bleeding	Sexual problem	Menstrual probs.		
General:	Change in weight	Fever			
Skin:	Lumps or Nodules	Breast lump	Rashes	Sores	Other skin problems
Eyes:	Glaucoma	Cataracts			
ENT:	Trouble swallowing	Nose Bleeds	Dentures	Sinus problems	Earaches
Heme/Lymph:	Swollen nodes or glands	Bleeding problems	Anemia	Other blood disorders	
C/V:	Irregular heart beat	Heart failure	Angina	Heart valve problem	Heart murmur
	Pain in the legs	Chest pain	Phlebitis	Swelling in legs	Blood clots
Respiratory:	Shortness of breath	Wheezing	Cough	Asthma	Other lung problems
G/I:	Gall bladder problems	Blood in stool	Diarrhea	Dark tarry stools	Intestinal bleeding
Neuro:	Loss of consciousness	Headaches	Strokes	Dizziness	Paralysis
Psych:	Other psychological problem	Depression	Anxiety		
Musculoskeletal:	Joint Replacement Surgery	Broken bones	Gout	Arthritis	Bone or joint pain
Endocrine:	Heat or cold intolerance	Hot flashes	Flushing	Abnormally thirsty	Changes in body hair
	Skin pigmentation changes				

Do you have any other problem you want to discuss with the doctor? Yes ☐ No ☐

_____

Patient's Signature