Date of Birth: _____
Name:

Patient History Form

Reason for Visit

Please describe your reason for today's visit:_____

What are you hoping to get out of today's visit?_____

How long has this been going on?_____

Does anything make your condition worse: □ No □ Yes Please describe_____

Does anything particular help with your condition: □ No □ Yes Please describe_____

Medications/Allergies – Please document any medications you are currently taking.

□ Please check if NO current medications

	Name	*Dose (Strength)*	*How Many?*	*How Often?*
Example:	*Aspirin*	*81mg*	*1 tablet*	*Daily*

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____

Do you take aspirin? No Yes **If yes, please enter above**

Do you take other blood thinners? No Yes **If yes, please enter above**

Have you taken any steroids (i.e. prednisone or cortisone) within the last 6 months? No Yes

If yes, what kind of steroid? Name: _____ Dose: _____ For how long? _____

When was the last dose?_____

Do you have any medication allergies? No Yes If yes, please list below:

1. _____ **What type of reaction?** _____
2. _____ **What type of reaction?** _____

Are you allergic to latex? No Yes **What type of reaction?** _____

Have you ever had the Pneumonia Vaccine? □ No □ Yes If yes, when:_____

Preferred pharmacy name: _____ **Pharmacy Phone:** _____

Pharmacy address: _____

In the event of a medical emergency, who may we contact? Name: _____

Relationship: _____ Phone: _____

Review of Systems – Please check any symptoms you are currently experiencing.

Constitutional

Chills	No	Yes
Fatigue or Weakness	No	Yes
Fever	No	Yes
Recent weight gain of 10 or more lbs.	No	Yes
Recent unplanned weight loss of 10 or more lbs.	No	Yes

Hearing/Eyes/Vision (HEENT)

Loss of hearing / Diminished hearing	No	Yes
Loss of vision / Change in vision	No	Yes

Respiratory

Chronic or frequent coughing	No	Yes
Shortness of breath	No	Yes

Cardiovascular

Chest pain	No	Yes
Irregular heartbeat (palpitations)	No	Yes

Gastrointestinal

Abdominal pain	No	Yes
Blood in stools	No	Yes
Change in stools	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Accidental Bowel Leakage (ABL)	No	Yes
Loss of appetite	No	Yes
Nausea	No	Yes
Vomiting	No	Yes

Genitourinary

Pain with urination (dysuria)	No	Yes
Blood in urine (hematuria)	No	Yes
Urinary incontinence (leakage of urine)	No	Yes

Reproductive (Females)

Painful intercourse (dyspareunia)	No	Yes

Integumentary (Skin)

Itching (pruritus)	No	Yes
Rash	No	Yes

Neurological

Dizziness / Light headed	No	Yes
Extremity numbness / Tingling	No	Yes
Headaches	No	Yes
Memory loss	No	Yes
Seizures	No	Yes

Psychiatric (Mental Health)

Anxiety	No	Yes
Depression	No	Yes

Metabolic/Endocrine

Cold intolerance	No	Yes
Heat intolerance	No	Yes
Excessive thirst or urination (polydipsia)	No	Yes

Musculoskeletal

Back pain	No	Yes
Joint pain	No	Yes

Hematologic/Lymphatic (Bleeding)

Easy bleeding	No	Yes

Problem List – Please check any problem you have had or you are being treated for.

□ Please check this box if NO current medical problems.

Blood Problems
- Anemia *D64.9*
- Blood clots (DVT/ Embolism) *Z86.718*
- Bleeding disorder *D69.9*
- Clotting disorder *D68.9*
- HIV positive *Z21*

Cardiac Vascular
- Angina (chest pain) *I20.9*
- Arrhythmia (heart rhythm problems) *I49.9*
- Atrial fibrillation *I48.91*
- Heart failure *I50.9*
- Hyperlipidemia: (high cholesterol) *E78.5*
- Hypertension: (high blood pressure) *I10*
- Malignant hyperthermia *T88.3*
- Past heart attack *I25.2*
- Peripheral vascular disease: (Blood vessel problems in legs) *I73.9*

Cancer
- Anal cancer *C21.0*
- Bladder cancer *C67.9*
- Breast cancer (Female) *C50.919*
- Breast Cancer (Male) *C50.929*
- Cervical cancer *C53.9*
- Colon cancer *C18.9*
- Kidney cancer *C64.9*
- Ovarian cancer *C56.9*
- Penile cancer *C60.9*
- Prostate cancer *C61*
- Rectal cancer *C20*
- Small bowel cancer *C17.9*
- Stomach cancer *C16.9*
- Urinary tract cancer *C68.9*
- Uterine (endometrial) cancer *C55*
- Vulva cancer *C51.9*

Other Cancer:_____

Eyes
- Glaucoma *H40.9*
- Vision loss *H54.7*

Endocrine
- Adrenal disease *E27.9*
- Diabetes *E13.9*
- Hyperthyroidism (high thyroid disease) *E05.90*
- Hypothyroidism (low thyroid disease) *E03.9*

Gastrointestinal
- Accidental bowel leakage *R15.9*
- Anal/Rectal trauma/injury *S36.60*
- Celiac disease (gluten sensitivity) *K90.0*
- Colon/Rectal polyps *Z86.010*
- Crohn's disease *K50.90*
- IBS (Irritable bowel syndrome) *K58.9*
- Ulcerative colitis *K51.919*

Infection
- Hepatitis *Z22.50*
- MRSA *Z22.322*
- VRE *Z22.39*

Kidney/Urinary
- Poor kidney function *N28.9*
- Renal failure *N18.9*
- Urinary incontinence (leakage of urine) *R32*

Mental Health
- Anxiety *F41.9*
- Depression *F32.9*

Musculoskeletal
- Arthritis *M19.90*
- Back problems *M53.9*
- Gout *M10.9*
- Pelvic fracture *S32.9XXS*

Neurological
- Multiple sclerosis *G35*
- Neuropathy *G62.9*
- Seizures *R56.9*
- Spinal cord injury
  - Cervical *S14.109A*
  - Thoracic *S24.109A*
  - Lumbar *S34.109A*
  - Sacral *S34.139A*
  - Unknown *Z87.828*
- Stroke (Cerebrovascular accident) *Z86.73*
- Brief stroke (Transient ischemic attack - TIA) *Z86.73*

Respiratory
- Asthma *J45.998*
- COPD *J44.9*
- Respiratory Tuberculosis *A15.9*
- Sleep apnea *G47.30*
- Other:_____

Female specific:
- Abnormal pap smears
  - Anus *R85.619*
  - Cervix *R87.619*
  - Vaginal *R87.629*
- Genital warts *A63.0*

Male specific:
- Abnormal pap smear anus *R85.619*
- Enlarged Prostate *N40.0*
- Genital warts *A63.0*

Other medical problem not listed above:
_____

Females Only: Your Obstetric History (OBGYN Detail)

Are you currently pregnant? **No** **Yes** **Possible** **Number of pregnancies: _____G**

Number of live births: _____P Number of C-Sections: _____ Number of vaginal deliveries: _____

Did you have a tear/laceration during delivery? No Yes Which Pregnancy?____

Did you have an episiotomy during any delivery? No Yes Which Pregnancy?____

Was forcep extraction used for any delivery? No Yes Which Pregnancy?____

Was vacuum extraction used for any delivery? No Yes Which Pregnancy?____

Did you experience Accidental Bowel Leakage (ABL) after any delivery? No Yes Which Pregnancy?____
If yes, how long? _____
If yes, did your accidental bowel leakage (ABL) resolve (stop)? No Yes

Did you notice the passage of gas through your vagina after any delivery? No Yes Which Pregnancy?____

Surgery/Procedures - Please check all that apply and indicate the year the surgery was performed.

□ Please check this box if NO past surgeries.

Abdominal Surgery

Appendectomy (appendix) *Year*_____
Cholecystectomy (gallbladder) *Year*_____
Hernia repair *Year*_____
Gastric bypass (weight loss surgery) *Year*_____
Abdominoplasty (tummy tuck) Year_____

Bowel Surgery

Colectomy (Removal of a portion of large intestine / colon) *Year*_____
Small bowel resection (Removal of a portion of small intestine) *Year*_____
Colostomy *Year*_____
Ileostomy stoma Year_____
Closure of ileostomy or Colostomy Year_____
Parks pouch (Ileoanal Reservoir) Year_____
Rectal prolapse repair (Abdominal) Year_____
Rectal prolapse repair (Anorectal) Year_____

Bowel Incontinence Surgery

Anal sphincter repair Year_____
Sacral nerve stimulation Year_____
Other_____ Year_____

Anal or Rectal Surgery

Sphincterotomy (fissure surgery) Year_____
Fistula surgery Year_____
Rectovaginal fistula repair Year_____
Hemorrhoid surgery Year_____
Pilondal cyst surgery Year_____
Drainage of abscess Year_____

Cardiac (heart)/Vascular (blood vessels)

Aortic aneurysm repair / Aortic bypass Year_____
Cardiac pacemaker *Year*_____
Defibrillator Year_____
Heart stents Year_____
Heart valve placement Year_____
Coronary bypass (CABG) *Year*_____

Transplant Surgery

Heart Year_____
Lung Year_____
Kidney Year_____
Liver Year_____

Orthopedic Surgery

Hip replacement *Year*_____
Knee replacement *Year*_____
Back surgery
- *Cervical* *Year*_____
- *Lumbar* *Year*_____
- *Thoracic* *Year*_____

Female Specific Surgery

Breast augmentation Year_____
Mastectomy Year_____
Cervical procedure (LEEP/CONE) Year_____
C-section Year_____
Hysterectomy – Abdominal Year_____
Hysterectomy – Vaginal Year_____
Removal of tubes and ovaries Year_____
Infertility surgery Year_____
Rectocele / Enterocele repair Year_____
Urinary incontinence procedures Year_____
Bladder repair / Cystocele repair Year_____
Sling Year_____
Vaginal prolapse repair Year_____

Male Specific Surgery

Removal of prostate Year_____
Prostate radiation Year_____

Miscellaneous Surgery

Dental / Oral surgery Year_____
Tonsillectomy Year_____
Other_____ Year_____

Other Surgery

Other_____ Year_____

Other_____ Year_____

Have you had any major problems with anesthesia? 419914000 No Yes _____
Have you had any excessive bleeding problems with surgery? 110265006 No Yes _____

Diagnostic Studies – Please check all that apply and indicate location and date study was performed.

□ Please check this box if NO diagnostic studies have ever been performed.

Colonoscopy	Location/Facility:_____	Date:_____
Flexible Sigmoidoscopy	Location/Facility:_____	Date:_____
CT of Abdomen/Pelvis	Location/Facility:_____	Date:_____
CT-PET	Location/Facility:_____	Date:_____
Transit Time Study	Location/Facility:_____	Date:_____
Mammogram (Females)	Location/Facility:_____	Date:_____
Anal Pap (cytology)	Location/Facility:_____	Date:_____

Your Family History – For any of your family members, please check all that apply.

☐ Please check this box if NO relevant family history.

If yes, please indicate the family member and if that member was maternal (mother's side) or paternal (father's side).

	Family Member	Maternal or Paternal	Age Diagnosed	Age Deceased
Colon Cancer				
Rectal Cancer				
Celiac Disease				
Colon Polyps				
Crohn's Disease				
Ulcerative Colitis				

Cancer:

Bile Duct /Gallbladder Cancer			
Bladder Cancer			
Brain Cancer			
Breast Cancer			
Endometrial Cancer			
Gastric (Stomach) Cancer			
Kidney Cancer			
Ovarian Cancer			
Small Intestine/ Small Bowel Cancer			
Uterine Cancer			
Other Cancer Type			

Factor V Leiden Deficiency			
Hemophilia			
Malignant Hyperthemia			
Von Willebrand's Disease			

Personal Habits / Social History

Have you ever used tobacco? ☐ No/never ☐ Yes ☐ Formerly -- Age Quit:_____

Smoking Tobacco Use (former and current):

- ☐ Cigarette _____ cigarettes/packs per day (circle one)
- ☐ Cigarillo _____ per day
- ☐ Cigar _____ per day
- ☐ Pipe _____ per day

Non-Smoking Tobacco Use (former and current):

- ☐ Chewing _____ units per day
- ☐ E-cig _____ units per day
- ☐ Snuff _____ units per day

Do you consume alcohol? No/Never Yes Formerly (in the past) **Type:** Beer Wine Liquor

How many drinks at a time? 1-2 3-5 6-9 10+ **How often?** _____

Are you currently: Single Married Partnered

Are you currently employed? No Yes **Occupation:** _____

Have you ever used drugs? No Yes Formerly (in the past)

Have you ever had anal sex? No Yes

HIV Status: ☐ Negative ☐ Positive ☐ Not Tested