PROVIDENCE MEDICAL PARTNERS

PATIENT HISTORY FORM

DATE TODAY:________________

WE STRIVE TO KEEP ALL INFORMATION IN CONFIDENCE AND WILL NOT RELEASE WITHOUT SIGNED CONSENT. It may be sent to consultants, if referred.

NAME:____Birth date: ____________________ AGE:__________
LAST FIRST M.I.

MARITAL STATUS: ( ) SINGLE; ( ) MARRIED; ( ) WIDOWED; ( ) SEPARATED; ( ) DIVORCED

OCCUPATION:____

REASON FOR VISIT TODAY:____
LAST MEDICAL EXAM: ____________________ **LAST DOCTOR:**____________________
LAST CHEST X-RAY (Date and location):____

ALLERGIES (DRUGS, X-RAY DYE, TAPE, LATEX) **& type of reaction**:____________________
____

PHARMACY NAME & PHONE #:____

MEDICATIONS: (LIST ALL MEDICATIONS, INCLUDING THOSE NOT PRESCRIBED, SUCH AS ALTERNATIVE AGENTS OR HERBAL AGENTS).

	DRUG	STRENGTH	HOW OFTEN YOU TAKE PER DAY	LENGTH OF TIME YOU HAVE TAKEN
i.e.:	Advil	200 mg	3 times per day	6 months

Please know what drugs and doses you take; if you need refills let the nurse know when she places you in the exam room.

CHILDHOOD ILLNESSES: Chicken Pox ( ) Measles/Rubeola ( ) Mumps ( ) Rubella ( ) Scarlet fever ( )

PREVIOUS MEDICAL ILLNESS/HOSPITALIZATION (other than under surgery):____________________
____
____

***If Diabetic**, do you self-test with glucose meter?__________ Do you get yearly eye exams?____ Have you been to a self- management course?__________ Do you know what to do for low blood sugar?____________ Foot care?_____ HgbA1C current value?__________

SURGERY: (IF YES, PLEASE CHECK ( ) AND GIVE APPROXIMATE DATE IN BLANK SPACE)

( )Appendectomy______________ ( )C-Section________________ ( )Hernia repair_________________
( )Breast Biopsy______________ ( )Gallbladder______________ ( )Hysterectomy_________________ ( )Ovary: R__________L__________
( )Carotid artery______________ ( )Heart angioplasty__________ ( )Mastectomy _________________ ( )Stomach surgery________________
( )Cataracts_________________ ( )Heart bypass______________ ( )Prostate removal_______________ ( )Tonsillectomy_________________

OB/GYN History: Pregnancies: #________ Deliveries: #____________ Last menstrual cycle:________________

****Check _X_ if YES, or write "NO" in front of the items below:**

_______Tobacco use # of packs per day:______________# of years:_____________
Are you interested in stopping? Yes _______________ No____________
_______Tobacco use in past When did you stop?____________________

If you continue to smoke, exercise regularly! When ready to stop, call if you want help

_______Alcohol use Beer_______ Wine________ Liquor_______ ounces/glasses/cans per week onaverage):_________

***** Do not mix drinking and driving please. *****

_______Caffeine use Coffee:________cups per day Sodas:_________ cans/ounces per day:

_______Exercise Type:_________________ Times per week:_______________

*** Goal of 30 minutes of walking-type exercise 5 days per week recommended. ***

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DATE______________________________________

NAME:____ ______________________________

Last First M.I. Date of Birth

FAMILY HISTORY: Place an "X" in the space next to the condition that your family member has, then specify their relation to you after the condition, using the following abbreviations:

Mother (M); Father (F); Brother (B); Sister (S); Grandparent (GP); Aunt (A); Uncle (U)

*For example, if your Aunt and Mother had breast cancer: (X) Breast Cancer _A, M_*

( ) Alcoholism___________	( ) Colon Polyps___________	( ) High Blood Pressure__________	( ) Prostate cancer___________
( ) Anemia______________	( ) Colon cancer___________	( ) Iron Disease_________________	( ) Seizures_________________
( ) Asthma______________	( ) Diabetes_______________	( ) Kidney Disease_______________	( ) Thyroid disease___________
( ) Arthritis______________	( ) Glaucoma______________	( ) Mental Illness________________	( ) Tuberculosis_____________
( ) Bleed easily___________	( ) Gout_________________	( ) Migraine____________________	
( ) Breast Cancer_________	( ) Heart Disease___________	( )Osteoporosis_________________	

LIVING	AGE OR AGE AT DEATH.	Present health or cause of death
FATHER ( ) Yes ( ) No	______________________	____
MOTHER ( ) Yes ( ) No	______________________	____
SIBLING ( ) Yes ( ) No	______________________	____
SIBLING ( ) Yes ( ) No	______________________	____

Immunizations: (Please check the disease against which you have been immunized and date of last booster.) **Tetanus or Td booster is due every 10 years**. Let the nurse know if you are due for a booster.

( ) Hepatitis B________________	( ) Tetanus___________________	( ) Measles/Mumps/Rubella__________________
( ) Pneumonia________________	( )Heapatitis A________________	( ) D.T. (Diphtheria/Tetanus)________________
( ) Varicella___________________	( )Flu Vaccine________________	( ) Meningitis vaccine_______________________

***If you have Hepatitis C or chronic liver disease, talk to your doctor about keeping up to date with your shots. You may benefit from Hepatitis A or B vaccine, or even the Pneumonia shot.

***If you have lung disease, keep up to date with the Influenza and Pneumonia shots.

Illicit Drugs Use? Please discuss with your physician.

Risk factors for AIDS & Hepatitis B and C are the following. If any apply, please let your physician know during your visit. We will observe confidentiality.

Blood transfusion; homosexual relations; IV drug use; relations with IV drug user; needle sticks; work with body fluids, such as dental work, nursing, ER, etc.; sex with multiple partners.

Mark with an "X" if YES or write "NO", for the following items.

______ **Diet:** Are you interested in information on diets for weight or cholesterol or diabetes?

______ **Calcium intake:** Do you know women need about 1000mg of calcium intake per day?

______ **Bone Density tests:** check if interested in information; considered after age 50 in women.

______ **Colon exams:** Did you know most experts recommend a colon exam every 5 years, after age 50? Please let us know if you have a family history of colon cancer.

______ **Mammography:** recommended yearly in women after age 40; check if due for this test.

Safety Measures: Examples of action you can take are: Seat belts (every time), bicycle helmets (even adults), wrist protection during roller-blading, eye protection (weed-eating, power sawing, etc.), proper gun use (locking, unloading, keeping out of children's access).

Advanced Directives: Please discuss with your spouse or family and your physician.

Living Will: No ( ) Yes ( ) Organ Donor: No ( ) Yes ( )

Durable Power of Attorney for Health Care: No ( ) Yes ( ) Who is your POA for Health Care?_________________________

____

PATIENT HISTORY FORM

DATE______________________________

NAME:____ ____________________

Last First M.I. Date of Birth

PLEASE PLACE A "**Y**" BY THE CURRENT COMPLAINT OR ALIMENT THAT APPLIES TO YOU, IF UNSURE, PLACE A QUESTION MARK "?", IF IT DOES NOT APPLY, PLACE AN "**N**".

HEAD
_____ BLURREDVISION
_____ LAST EYE EXAMDATE
_____ GLAUCOMA
_____ FREQUENTHEADACHES
_____ MIGRAINEHEADACHES
_____ LUMPSORSWELLINGINNECK
_____ CONSTANTRINGINGINEARS
_____ HEARINGPROBLEMS
_____ FREQUENTEARACHES
_____ FREQUENTNOSEBLEEDS
_____ SINUSINFECTION
_____ ALLERGIES/HAYFEVER
_____ HOARSEVOICE,PERSISTENT
_____ MOUTHORTONGUESORES

LUNGS
_____ ASTHMA
_____ HAVECOUGHEDUPBLOOD
_____ INCREASINGSHORTNESSOFBREATH WITHACTIVITY
_____ EMPHYSEMA
_____ HISTORYOFTUBERCULOSIS
_____ CHRONICCOUGH

HEART
_____FREQUENTIRREGULARHEARTBEAT
_____ CHESTPAINORTIGHTNESSINCHEST
_____ HEARTMURMUR_________Mitral valve prob.
_____ HISTORYOFENLARGEDHEART
_____ SHORTNESS OFBREATHATNIGHT
_____ SWELLINGOFFEET, ANKLESPRESENT AFTERSLEEP
_____ HISTORYRHEUMATICFEVER
_____ HIGHBLOODPRESSURE
_____ PREVIOUS HEART ATTACK

ABDOMEN
_____FREQUENTHEARTBURN
_____ DIFFICULTYORPAININSWALLOWING
_____ HAVEVOMITEDBLOOD
_____ RECTALPAINORBLEEDING(BLACK ORBLOODY)
_____ RECENTCHANGEINBOWELHABITS
_____ DIVERTICULITISorDIVERTICULOSIS
_____ COLONPOLYPS
_____ Last Colon exam date:__________________
_____ HEPATITIS / YELLOWJAUNDICE/
_____ LIVERDISEASE
_____ NAUSEA
_____ CONSTIPATION
_____ DIARRHEA; how often per day_____________
_____ ABDOMINAL PAIN WITH Fatty Food
_____ SUSPECTULCERS
_____ HEMORRHOIDS
_____ HISTORYOFULCERS
_____ BLEEDING

NEURO
_____LOSSOFAPPETITE
_____ SEIZURE
_____ LOSS OF CONSIOUSNESS
_____ DOUBLE VISION
_____ MEMORYLOSS
_____NUMBNESSOFHANDSORFEET
_____NERVOUSNESSAFFECTINGHOMELIFEORWORK
_____SPEECHPROBLEMS
_____STROKE

KIDNEY
_____RECURRENTURINARYTRACTINFECTION
_____URINATIONATNIGHT MORETHANONCE
_____BROWN,BLACKORBLOODYURINE
_____BURNINGONURINATION
_____KIDNEYSTONES
_____DIFFICULTYSTARTINGSTREAM
_____PROBLEMS WITHSEXUALFUNCTION
_____URINARYINCONTINENCE

JOINTS
_____BACKTROUBLE
_____SWOLLENJOINTS
_____FREQUENTPAINFULFEET
_____FREQUENTSHOULDERPAIN
_____FREQUENTORPERSISTENTACHINGOFMUSCLES OR JOINTS
_____GOUT
_____ARTHRITIS
_____OSTEOPOROSIS-How diagnosed?

GENERAL
_____DIABETES: Datediagnosed: ____________________
_____WEIGHTLOSS GREATERTHAN 10LBS IN LASTYR
_____LOSS OFINTERESTINEATING
_____SLEEPINGDIFFICULTY
_____HERPES IN PAST-genital or face
_____THYROIDPROBLEMS
_____BLOODPRESSUREPROBLEMS
_____MOLEORSORENOTHEALING
_____HOTORCOLDNATURED
_____SUSPECTSERIOUSDISEASEORCANCER
_____LEGCRAMPS WHILEWALKING
_____MORETHIRSTYLATELY
_____FATIGUE
_____FREQUENTCRYINGSPELLS,DEPRESSION
_____WORKORFAMILYPROBLEMS
_____ANXIETY
_____ANEMIA
_____HIGHCHOLESTEROL & last result__________________

MALES ONLY
_____WEAKURINESTREAM
_____PAINFULORSOREGENITALS(PRIVATES)
_____PROSTATETROUBLE
_____HARDTOEMPTYBLADDERCOMPLETELY
_____PERFORM SELF TESTICLE EXAM MONTHLY
_____LASTPSATEST (if over age 50). DATE_______________

FEMALES ONLY
_____LASTMENSTRUALPERIOD____________________
_____VAGINAL DISCHARGEORPROBLEMS
_____ PAINFULORSOREGENITALS(PRIVATES)
_____LUMPS OR PAIN IN BREASTS
_____IFYOUSEE A GYNECOLOGIST, LISTNAME
____
_____**Last Bone Density Test** Date _______________
_____**LASTMAMMOGRAPHY** Date ______________
_____**LASTPAPSMEAR** Date____________________
_____ PERFORM SELF BREAST EXAM MONTHLY