Stafford Medical, P.A.

Patient History Form

Name:_______________________________________ Age:______ Date of Birth:____-____-____ SSN:_____-_____-_____
Phone: ______________________________ Cell:__________________________________ Sex: ❑ Male ❑ Female
How would you rate your general health? ❑ Excellent ❑Good ❑Fair ❑Poor
Reason for today's visit and other concerns: ____
____

Please check any current or recent symptoms:

CARDIOVASCULAR	
Do you ever have chest pain?	❑ No ❑ Yes
Do you ever have shortness of breath?	❑ No ❑ Yes
Can you climb a flight of stairs without getting short of breath?	❑ No ❑ Yes
Can you climb a flight of stairs without having chest pain?	❑ No ❑ Yes
Have you noticed any swelling? Where?___________________________	❑ No ❑ Yes
Do you have leg cramps when walking?	❑ No ❑ Yes
Have you ever been awakened by shortness of breath or chest pain?	❑ No ❑ Yes
Do you ever have palpitations (frequent or rapid extra beats)	❑ No ❑ Yes

RESPIRATORY	GASTROINTESTINAL	GENITOURINARY
❑Cough – how long?	❑Heartburn/Reflux	❑Painful/Bloody urination
❑Wheeze	❑Nausea/Vomiting	❑Leaking urine
❑Coughing up blood	❑Change in bowel movement	❑Nighttime or frequent urination
❑Allergies	❑Bloody stool (black)	❑Discharge: penis or vagina
❑Difficulty breathing	❑Pain in the abdomen	❑Unusual vaginal bleeding
❑Shortness of breath	❑Indigestion	❑Concern with sexual functions
❑Sputum when you cough	❑Change in appetite	❑Pelvic pain
What color is the sputum?		
❑White ❑Yellow ❑Green ❑Brown		

SLEEP	ENDOCRINE	NEUROLOGICAL
❑Snoring	❑Cold/Heat intolerance	❑Headaches
❑Excessive daytime sleepiness	❑Increase in thirst/appetite	❑Memory loss
❑Observed periods of not breathing (apnea)	❑High/Low blood sugars	❑Fainting
❑Insomnia	❑Hot flashes	❑Dizziness
❑Acting out dreams	❑Excessive urination	❑Numbness
❑Sleep talking or sleep walking		❑Convulsions/Seizures

CONSTITUTIONAL	PSYCHIATRIC	SKIN
❑Weight gain or loss	❑Anxiety/Stress	❑Rash
❑Recent fevers/sweats	❑Sleep Problems	❑New mole or change in mole
❑Unexplained fatigue/weakness	❑Depressed	❑Hair loss
❑Pain - location		❑Open wound

EARS/NOSE/THROAT/MOUTH	MUSCULOSKELETAL	BLOOD/LYMPHATIC
❑Difficulty hearing/ringing in ears	❑Muscle pain	❑Unexplained lumps
❑Allergies/Congestion/Hay Fever	❑Joint pain	❑Easily bruised
❑Trouble swallowing	❑Recent fall	❑Prolonged bleeding
❑Post nasal drip		

EYES	BREAST	OTHER
❑Change in vision	❑Breast lump	
	❑Nipple discharge	

- Did you fall in the last 12 months? ❑ Yes ❑ No If yes then how many times?______________
- During the past month, have you often been bothered by feeling down, depressed or hopeless? ❑ Yes ❑ No
- During the past month, have you often been bothered by little interest or pleasure in doing things? ❑ Yes ❑ No
- **Surgical history and hospitalizations with dates:**____

____

____

MEDICATIONS: Prescription, non-prescription, over the counter (OTC), vitamins, home remedies, birth control, herbs.

MEDICATIONS	DOSE (MG/PILL)	TIMES PER DAY	OTC MEDS/SUPPLEMENTS

Allergies or reactions to medications, x-ray dyes, other substances (include type of reaction):____

____

____

____

Date of your most recent immunizations:

HEP A:	MENINGITIS:	FLU SHOT:	VARICELLA (CHICKEN POX):	PNEUMONIA:
HEP B:	TETANUS (Td):	MMR:	ZOSTAVAX (SHINGLES):	Tdap:

Health Maintenance Screening Tests:

Test	Date	Abnormal
Lipid (Cholesterol)	Date:	Abnormal? ❑ Yes ❑ No
Colonoscopy / Sigmoidoscopy	Date:	Abnormal? ❑ Yes ❑ No
Dexascan (Osteoporosis)	Date:	Abnormal? ❑ Yes ❑ No
Men: PSA (Prostate)	Date:	Abnormal? ❑ Yes ❑ No
Women: Mammogram	Date:	Abnormal? ❑ Yes ❑ No
Women: Pap Smear	Date:	Abnormal? ❑ Yes ❑ No

Personal History: Please indicate whether you currently have or have had any of the following medical problems (with dates).

Heart Disease (type)	High Blood Pressure	High Cholesterol
Asthma/Lung Disease	Diabetes	Thyroid Problem
Cancer (type)	Kidney Disease	Psychiatric
Bleeding Disorders	Arthritis (type)	Immunologic Disease (type)
Other:		

Family History: Please indicate the current status of your immediate family member

Family History	Age	If living: Health	Age at Death	If Deceased: Cause
Father				
Mother				
Siblings:				

Please indicate family members with any of the following. Write their relationship to you and the date it started:

High Cholesterol	High Blood Pressure	Stroke
Cancer (type)	Diabetes	Heart Disease
Genetic Disorders	Asthma/COPD	Bleeding disorder
Substance abuse	Depression/Anxiety/Suicide	Other

Exercise: Do you exercise regularly? ❑ No ❑ Yes If you do not exercise, why?________________________________
What kind of exercise, how long, and how often?____

Tobacco: ❑ Never ❑ Former: Quit date ________ packs/day________# of years previously smoked
❑Current Smoker: packs/day_________ # of years_________
Other Tobacco: ❑ Pipe ❑Cigar ❑Snuff ❑Chew Are you interested in quitting? ❑Yes ❑No

Caffeine Intake: ❑None ❑ Coffee / Tea / Soda _______cups/day

Drugs and Alcohol:
Do you drink alcohol? ❑No ❑Yes ____# of drinks per week?
Is your alcohol use a concern for you or others? ❑ No ❑Yes
Do you use any recreational drugs? ❑ No ❑Yes Have you ever used needles to inject drugs? ❑ No ❑Yes
Are you sexually active? ❑ No ❑Yes ❑Not Currently Current sexual partner(s) is/are: ❑ Male ❑ Female
Birth Control Method:_______________ Have you ever had a sexually transmitted disease (STD)? ❑ No ❑ Yes
Are you interested in being screened for sexually transmitted diseases? ❑ No ❑ Yes

Safety:
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ❑ No ❑ Yes
Is violence at home a concern for you? ❑ No ❑ Yes Have you ever been abused? ❑ No ❑ Yes
Do you have a living will or a durable power of attorney for healthcare? ❑ No ❑ Yes

Primary Language:_________________________________ Race/Ethnicity: _______________________________________
Occupation:___________________________________ Currently employed: ❑ No ❑ Yes
Marital status: ❑Single ❑Married/Partner ❑Divorced ❑Widowed Spouse/Partner name:______________________
Number of living children/ages:____
Who lives at home with you?____
Women's Health History: # pregnancies:________ # deliveries:_________ # abortions:_______ # miscarriages:_______
Age at start of period:___________ Age at end of period:__________

Patient Signature____ Date______________________

Physician Signature____ Date______________________