FAMILY MEDICINE OF SCOTTSDALE

Patient History Form

To prevent medical errors it is critical you complete this form completely and accurately!

First Name: _____ Last Name: _____ Date: _____

Height: _____ ft _____ in Weight: _____ lbs Age: _____ Occupation: _____ Retired: ☐Yes ☐No

Race: _____ Primary Language: _____ Ethnic Group: _____

How did you hear about us: ☐Friend ☐Internet (which site?) _____ ☐Insurance Company ☐Other, How? _____

	Current Physicians	**City**	**Phone #**	**Fax #**	**Specialty**
☐PCP ☐Referring					
☐PCP ☐Referring					

CHIEF COMPLAINT *(Why do you want to see the doctor?)* _____

How long have you had this complaint? _____

MEDICATIONS *(List all* ***Prescription*** *drugs you are taking with dosage and schedule)* ☐See Attached List

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

List all ***Non-Prescription*** *drugs:*

Vitamins: _____ Aspirin / Ibuprofen: _____

Other (including supplements): _____

ALLERGIES *(List all allergies to drugs or foods (i.e., sulfa, shellfish))* ☐No Known Allergies ☐See Attached List

_____

PATIENT MEDICAL HISTORY *(Do you have any of the following:)*

Asthma	☐Yes	☐No	Glaucoma	☐Yes	☐No	Osteoarthritis	☐Yes	☐No
Atrial Fibrilation	☐Yes	☐No	Heart Disease	☐Yes	☐No	Peripheral Vascular Dis.	☐Yes	☐No
Cancer	☐Yes	☐No	Hepatitis	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Type: _____			Hyperlipidemia	☐Yes	☐No	Thyroid Disorder	☐Yes	☐No
CVA / Stroke	☐Yes	☐No	Hypertension	☐Yes	☐No	Urinary Incontinence	☐Yes	☐No
Depression	☐Yes	☐No	Liver Disease	☐Yes	☐No	UTI Recurrent	☐Yes	☐No
Diabetes	☐Yes	☐No	Myasthenia Gravis	☐Yes	☐No	Vascular Disease	☐Yes	☐No
DVT	☐Yes	☐No	Neurologic Disorder	☐Yes	☐No	No Medical Problems	☐Yes	☐No

Other Medical Problems/Prior Hospitalizations: ☐No ☐Yes. If yes, type and date: _____

_____

PREVIOUS SURGERIES: ☐Yes ☐No If yes, please complete the below.

Type	Date	Type	Date

FAMILY HISTORY *(Please fill out as complete as possible – # of children, status, check boxes)*

	Status (Alive/Dead)	Age	Prostate Cancer	Kidney Cancer	Bladder Cancer	Breast Cancer	Diabetes	High Blood Pressure	Heart Disease
Daughters (#)			☐	☐	☐	☐	☐	☐	☐
Sons (#)			☐	☐	☐	☐	☐	☐	☐
Father	A/D		☐	☐	☐	☐	☐	☐	☐
Mother	A/D		☐	☐	☐	☐	☐	☐	☐
Grandparent			☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐
Other Family History?:									

SOCIAL HISTORY

Current Tobacco use? ☐Yes ☐No Prior Tobacco use? ☐Yes ☐No Alcohol use? ☐Yes ☐No Current Drug use? ☐Yes ☐No

Exercise? ☐Yes ☐No Type: _____ Caffeine use? (Cups / Day): Coffee: _____ Tea: _____ Cola: _____

REVIEW OF SYSTEMS (Have you currently or recently had)

General
Fatigue ☐Yes ☐No
Fever ☐Yes ☐No
Weight Gain ☐Yes ☐No
Weight Loss ☐Yes ☐No

Allergy
Drug Allergies ☐Yes ☐No
Seasonal Allergies ☐Yes ☐No

Opthalmologic
Blurred Vision ☐Yes ☐No

ENT
Dry Mouth ☐Yes ☐No
Nosebleeds ☐Yes ☐No

Endocrine
Cold Intolerance ☐Yes ☐No
Excessive Sweating ☐Yes ☐No
Heat Intolerance ☐Yes ☐No

Cardiovascular
Chest Pain ☐Yes ☐No
Edema (swelling) ☐Yes ☐No
Palpitations ☐Yes ☐No

Respiratory
Shortness of Breath ☐Yes ☐No
Cough ☐Yes ☐No

Gastrointestinal
Constipation ☐Yes ☐No
Diarrhea ☐Yes ☐No
Nausea ☐Yes ☐No
Bloody/Tarry Stools ☐Yes ☐No

Hematology
Bleeding Problems ☐Yes ☐No

Musculoskeletal
Back Pain ☐Yes ☐No
History of Gout ☐Yes ☐No

Peripheral Vascular
Blood Clots in Legs ☐Yes ☐No

Skin
Rashes ☐Yes ☐No

Neurologic
Leg or Arm Weakness ☐Yes ☐No
Balance Difficulty ☐Yes ☐No
Headaches ☐Yes ☐No

Psychiatric
Depressed Mood ☐Yes ☐No

Urology
Frequency/Urgency ☐Yes ☐No
Incontinence ☐Yes ☐No
Blood in Urine ☐Yes ☐No

Gynecology
Period Irregularity ☐Yes ☐No
Painful Periods ☐Yes ☐No
Abnormal Pap Smear ☐Yes ☐No

Date of Last (Mo/Yr):
Flu Shot _____
Pneumonia Shot _____
Colonoscopy _____
DEXA Scan _____

Females
Mammogram _____
Annual Pap _____

Patient Health Questionnaire (PHQ-9) (Over the last 2 weeks, how often have you been bothered by any of the following?)

	Not at all	Several days	More than half the days	Nearly every day		Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3	Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Feeling tired or having little energy	0	1	2	3					
Poor appetite or overeating	0	1	2	3	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Form Completed By: _____ Date: _____