UNION GENERAL HOSPITAL CLINICS

PATIENT HISTORY FORM

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: (____)_____Cell Phone: (____)_____

Patient's Employer: _____ Employer Phone No.: (____)_____

Please list all of the medications you are taking. Include over-the-counter medications, herbs & vitamins.

Medication Name	Dose & how often you take medication (e.g., 25mg twice daily)	For what condition? (e.g., Blood Pressure, cholesterol, pain)

Please indicate any drug allergies.

NAME OF MEDICATION	REACTION

Please indicate any Vaccines/Injections

VACCINE/INJECTION	Yes	No	Date:
Hepatitis A			
Hepatitis B			
DTAP/TD			
MMR			
Flu			
Shingles			
Pneumonia 13			
Pneumovax 23			
Tetanus			
Varicella Vaccine			
Other			

FAMILY HISTORY

Please indicate any health conditions that apply to **Mother, Father, Siblings, and/or Children**

CONDITION	Who?	DESCRIPTION
Heart Disease		
Stroke		
Diabetes		
Cancer		
Lung Disease/Breathing Problems		
Liver Disease		
Kidney or Bladder Disease		
Mental Issues/Illness		
Other		

SOCIAL HISTORY

Marital Status: (Single) (Married) (Divorced) (Widowed) (Other)

Highest Level of Education Completed: (Please Circle one) High School College Other

Do you work? (Yes) (No) Occupation:_____

Disabled? (Yes) (No) Why? _____

Do you Exercise? Yes No How Often: _____

What are your Hobbies? _____

Describe your current level of stress: (Low) (Medium) (High)

Do you live alone? Yes No

Use of Alcohol: Never Rarely Moderate Daily

Smoking Status: (Never) (Former) (Current Everyday) (Current Somedays) Number of Years: _____

Packs of cigarettes per day: 1-2 3-4 >4

Chewing Tobacco Use: (None) (1x daily) (2-4x daily) (5+ daily)

Use of Drugs: Yes No Type/frequency: _____

Are you currently experiencing vision problems? Yes No Describe: _____

Are you currently experiencing difficulty hearing: Yes No Describe: _____

Do you have an Advanced Directive? Yes No

SURGICAL HISTORY

SURGERY TYPE	DATE

PAST MEDICAL HISTORY

CONDITION	YES	NO	DESCRIBE
Arthritis			
Blood Disease			
Breast Problems			
Cancer			
Circulation Problems			
Diabetes			
Ear or Hearing Problems			
GI Problems			
Headaches			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Kidney or Bladder Disease			
Liver Disease			
Lung Disease/Breathing Problems			
Mental Issues/Illness			
Muscle/Joint/Bone Problems			
Skin Disease/Problems			
Sleep Apnea			
Stroke			
Thyroid Problems			
Vision or Eye Problems			
Other			

REVIEW OF SYMPTOMS

CONDITION	YES	NO	CONDITION	YES	NO
CONSTITUTIONAL			**GU**		
Weight Loss			Difficulty Urinating		
Weight Gain			Loss of Control/Leaking		
Fatigue			Increased Frequency		
Trouble Sleeping			Inability to Empty Bladder		
EYES			**MUSCULOSKELETAL**		
Changes in Vision			Back Pain		
ENT			Joint Pain		
Nosebleeds			Trouble Walking		
Sinus Problems			Neck Pain		
Sore Throat			Limited Range of Motion		
Bleeding/Sore Gums			**SKIN**		
Dry Mouth			Rashes		
Snoring			Growths/Lesions		
CARDIOVASCULAR			Trouble Healing		
Chest Pain			Change in Color		
Arrhythmia/Palpitations			**NEURO**		
Ankle Swelling			Frequent/Severe Headaches		
RESPIRATORY			Weakness		
Shortness of Breath			Dizziness		
Coughing			Numbness		
Wheezing			**PSYCH**		
GI			Depression		
Abdominal Pain			Anxiety		
Nausea			Memory Loss		
Vomiting			**ENDROCRINE**		
Black/Tarry Stools			Heat or Cold Intolerance		
Diarrhea			Excessive Thirst		
Reflux/Heartburn			**HEMATOLOGICAL/LYMPH**		
			Abnormal Bleeding		
			Bruise Easily		

What other physicians or specialists do you see?

	Name	Location/Phone #
Allergist		
Cardiologist		
Chiropractor		
Dermatologist		
E/N/T		
Gastroenterologist		
Nephrologist		
Neurologist		
Oncologist		
Ophthalmologist		
Orthopedist		
Psychiatrist		
Pulmonologist		
Rheumatologist		
Urologist		
Physical Therapist		
Dentist		
Other….		

QUALITY MEASURES

SCREENING	DATE	RESULTS
Annual Wellness/Physical		
Mammogram(female)		
Pap(female)		
Osteoporosis Screening(female)		
PSA(male)		
Colon Cancer Screening		
Lung Screening		
Hep C Screen(born 1945-1965)		
EKG		
Other		

Pharmacy:

Name	Phone Number

Patient signature:_____ Date:_____