**The Family Practice & Orthopedic Care Center, PC**
**Patient History Form**

**Name: _____ Date of Birth _____**
**Allergies: _____ Latex Allergy Yes/No Metal Allergy Yes/No**
**Food Allergy (please list):**

## *Past Surgical History:*

| Type of Surgery | Date | Type of Surgery | Date |
|---|---|---|---|
| _____ | | _____ | |
| _____ | | _____ | |
| _____ | | _____ | |

## *Review of Systems:*

**General**
__ chills
__ fever
__ dizziness
__ fainting
__ fatigue
__ forgetfulness
__ loss of sleep
__ weight gain / loss
__ nervousness
__ frequent sore throats
__ night sweats

**Skin**
__ hives
__ itching
__ easy bruising
__ rash
__ skin cancer

**Muskuloskeletal**
__ hip pain L / R
__ back pain
__ knee pain L / R
__ feet/foot pain L / R
__ neck pain
__ shoulder pain L / R
__ arm pain L / R
__ hand pain L / R
__wrist pain L / R
__ankle pain L / R

**Eyes**
__ blurred vision
__ failing vision
__ cataracts

**Ear/Nose/Throat**
__ ringing in ears
__ loss of hearing
__ nosebleeds
__ sinus problems
__ sore throats
__ hoarseness
__ difficulty swallowing

**Cardiovascular**
__ leg pain w/ walking
__ chest pain
__ irregular heartbeat
__ swollen ankles/feet

**Pulmonary**
__ chronic cough
__ productive cough/blood
__ shortness of breath
__ wheezing

**Gastrointestinal**
__ poor appetite
__ persistent nausea/vomiting
__ vomiting blood
__ indigestion
__ heartburn
__ chronic abdominal pain
__ bowel changes
__ constipation
__ diarrhea
__ bloody stools
__ tarry stools
__ hemorrhoids
__ jaundice

**Neuro**
__ headache
__ muscle weakness
__ numbness
__ tingling
__ cold, numb feet
__ tremor/hands shake
__ stroke/mini stroke

**GU**
__ frequent urination
__ infections,frequent
__ incontinence
__ nocturia

**GU (cont)**
__ pain w/ urination

**MEN Only**
__ sore on penis
__ erectile dysfunction
__ difficult start stream
__ dribbling
__ penile discharge

**WOMEN Only**
__ abn. Pap smear
__ bleed btn periods
__ extreme menstrual pain
__ vaginal discharge
__ menopause
___ # of pregnancies
__ miscarriages
__ LMP _____
length of cycle _____

last Mammogram
_____

Bone Density Exam:
_____

## *Past Medical History:*

__ AIDS
__ alcoholism
__ allergies
__ anemia
__ anorexia/bulimia
__ anxiety
__ Arthritis
__ asthma
__ bleeding disorders
__ blood clots
__ blood transfusion
__ breast lump
__ bronchitis
__ cataracts
__ chemical dependency
__ COPD
__ depression
__ diabetes Type 1 / Type 2
__ emphysema
__ epilepsy
__ fibromyalgia
__ glaucoma
__ goiter
__ gout
__ heart disease
__ Myocardial Infarction
__ Congestive Heart Failure
__ hepatitis
__ hernia
__ high cholesterol
__ high blood pressure
__ HIV +
__ kidney disease
__ liver disease
__ migraines
__ mononucleosis
__ multiple sclerosis
__ osteoporosis/osteopenia
__ pneumonia
__ prostate problems
__ psychiatric care
__ rheumatoid arthritis
__ sickle cell anemia
__ stroke
__ thyroid problems
__ tuberculosis
__ ulcer
__ vaginal infections
__ venereal disease
type: _____
__ lymphedema
__ MRSA
__Sleep Apnea

__ Cancer: _____

## *Family History:*

__ Alcoholism
__ Bleeding History
__ Cancer
__ Diabetes
__ Epilepsy/Convulsions
__ High Cholesterol
__ Stroke
__ Heart Disease
__ High Blood Pressure
__ Kidney Disease
__ Mental Illness
__ Migraine
__ Osteoporosis
__ Thyroid

## *Social History:*

**Alcohol** Consumption **Y / N** Type/Amount _____
**Smoke YES / NO** Packs per day _____ Years _____
**E-cigs / vapes** Subject to **2nd hand smoke** YES / NO
Stopped smoking_____ Year_____/ **Never Smoked**
**Marijuana** or other drug use: YES / NO _____
Do you have children? YES / NO # of children _____
Do you live ___ alone ___with family
**Single / Married / Widowed / Divorced / Life Partner**

***** PATIENT REVIEW: Consent and Signature attests that I have reviewed and updated/revised any known changes to this form as of:**
**Date: _____ Signature: _____**
**Reviewing Provider: _____ Date _____**