

ADVANCED MEDICAL CARE

PATIENT HISTORY (Please fill out completely)

Date

Patient Name:	Age:	DOB	Occupation:
Describe problem you are being seen for today			Referring M.D.
Current Medications:			Are you allergic to any medications Yes No
			List
			Are you allergic to latex? Yes No
			Pharmacy Name
			Pharmacy Phone No
Are you Disabled Yes No	Job Related	Military	Previously treated for this problem? Yes No
Is this work related? Yes No	Lawsuit involved?		Have you had recent X-Ray studies Yes No
Were you seen in the Emergency Room? Yes No	Where?		Where?

PATIENT HISTORY	REVIEW OF SYSTEMS	SOCIAL HISTORY
Anemia Yes	Prior Problem/Risk of Anesthesia Yes	Married Single Divorced
Arthritis Yes	Diseases of E yes Nose or Throat Yes	Number of Living Children?
Rheumatoid Arthritis Yes	Sinusitis Yes	Presently living alone?
Asthma/Emphysema Yes	Loss of Hearing Yes	Do You Smoke?
Back Disorders Yes	Indigestion, Hearburn Yes	If so, When did you quit
Bursitis Yes	Hiatal Hernia Yes	Alcohol Never Occasional
Bleeding Diseases Yes	Peptic Ulcer Yes	Moderate to Heavy
Cancer Where? Yes	Stomach Pain Yes	Drug Overuse Never
	Gallbladder Disease Yes	Present Past
Diabetes Yes	Bowel Disease (i.o Colitis, Diverticulitis) Yes	Previous Surgeries
Heart Disease Yes	Intestinal Bleeding Yes	Tonsils
Hepatitis Yes	Frequent Urination Yes	Gallbladder
High Blood Pressure Yes	Burning on Urination Yes	Appendix
HIV (Aids) Yes	Difficulty S tarting Urination Yes	Prostrate
Kidney Infection Yes	Shortness of Breath Yes	Hys terectomy/ovaries
Kidney Stone Yes	Chills or Fever Yes	Cancer
Lung Disease Yes	Hear/Chest Pain Yes	Back/Disc
Paralysis Yes	Angina Yes	Fracture
Phlebitis Yes	Abnormal Heart Beat Yes	Heart
Pneumonia Yes	Muscle Weakness Yes	Transplant
Rheumatic Fever Yes	Joint Pain/Swelling Yes	Other (List)
Stroke Yes	Calf Cramps Walking Yes	
Throid Disease Yes	Recent Weight Loss Yes	
TB Yes	Leg/Skin Ulcers Yes	
Other (List) Yes	Mental Illness Yes	
	Addiction Yes	
	Gout Yes	
	Psoriasis Yes	

FAMILY HISTORY - If a member of your family has had a history of any of the following conditions please check the box

Stroke	Aids/TB	Other	Major cause of death
Heart Trouble	Bleeding Disorder	Explain all Yes Answers:	Cancer
High Blood Pressure	Alcoholism		Diabetes
Diabetes	Seizures		Heart Disease
Arthritis	Mental Illness		Hypertension
Gout	Kidney Trouble/Stones		Accident
Cancer	Leukemia		

Reviewed with patient by: