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 Right/Left
__ back pain
__knee pain Right/Left
__ feet/foot pain Right/Left
__ neck pain
__ shoulder pain Right/Left
__ elbow pain Right/Left
__ hand pain Right/Left

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
__dementia
__ 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
__osteoarthritis
__ osteoporosis
__ pneumonia
__ prostate problems
__ psychiatric care
__ rheumatoid arthritis
__ sickle cell anemia
__ stroke
__ thyroid problems
__ tuberculosis
__ ulcer
__ vaginal infections
__ venereal disease
type: _____
__ lymphedema

__ MRSA
__Sleep Apnea

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 Type/Amount _____
__ Smoke YES / NO Packs per day _____ Years _____
Stopped smoking _____Year / NEVER SMOKED / Use of E cigs/vapes
Use of elicit drugs? YES / NO Subject to 2nd hand smoke YES / NO
Do you have children? YES / NO If so, how many? _____
Do you live __Alone __ Family __ Other
Marital Status Single / Married / Divorced/ Widowed / Life Partner

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