

Bridlewood Family Healthcare, P.A.
PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____/____/____

DATE OF LAST PHYSICAL EXAM ____/____/____

LAST NAME _____ FIRST NAME: _____

SOCIAL SECURITY No. _____ DATE OF BIRTH: ____/____/____ AGE _____

OCCUPATION. _____ MARITAL STATUS MARRIED SINGLE DIVORCED WIDOWED

Medical (*High Blood Pressure, Diabetes, Asthma, Cancer, Heart Disease, etc.*)

Surgical (*Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.*) None

Allergies to medications? None (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

Current prescription medicines				Current prescription medicines			
Name of drug	mg dose	# tablets	# times per day	Name of drug	mg dose	# tablets	# times per day
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

OTC medicines. (*Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals.*)

Family History

Father: Living - Age: _____ Deceased, Age at Death _____ (Cause) _____

Mother: Living - Age: _____ Deceased, Age at Death _____ (Cause) _____

Siblings: Number Living _____ Number deceased _____ (Cause) _____

List other illnesses in your family (Example - Diabetes, heart disease, colon cancer, breast cancer, prostate cancer, etc)

Family Member	Illness	Family Member	Illness	Family Member	Illness
_____	_____	_____	_____	_____	_____

Social History

Smoke? Yes No If yes, how much? ____ # of packs/day ____ # of years When did you stop smoking? _____

Alcohol? Yes No If yes, how much? _____

Exercise regularly? Yes No If yes, what and how frequently? _____

Routinely wear **seatbelts?** Yes No Routinely wear a **helmet?** Yes No Substance Abuse? Yes No

Review of Systems

Do you now or have you had any problems related to the following systems? write **Y**es or **N**o.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Last Eye & Dental Exam

Date - Last Eye Exam: _____

Date - Last Dental Exam: _____

Screening Exams

Cholesterol _____ Colonoscopy _____

PSA _____ Chest X-ray _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N
Other _____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Psychologic

Are you generally satisfied with your life? Y N

Do you feel severely depressed? Y N

Have you considered suicide? Y N

Sexual History

Change in sex drive? Y N

Sexual performance satisfactory? Y N

Other (i.e. sexual trauma) _____

Mammogram _____

Stress Test _____

Pelvic Exam _____

Blood Pressure _____