PLEASE PRINT CLEARLY

Bridlewood Family Healthcare, P. A.

DATE: _____ **PATIENT HISTORY FORM** LAST PHYSICAL EXAM: _____

Due to patient confidentially information contained here will NOT be released to anyone without your written authorization.

LAST NAME: _____ **FIRST NAME:** _____

PHONE NUMBER: _____ **DOB:** _____ **SEX:** _____ **OCCUPATION:** _____

AGE: _____ **MARITAL STATUS:** _____

ETHNICITY: Asian Black Caucasian Hispanic Non-Hispanic

MEDICAL HISTORY: *(High Blood Pressure, Diabetes, Asthma, Cancer, Heart Disease, etc.)*

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SURGICAL: *(Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)* ▯ *NONE*

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES to medications? ▯ *NONE* *(If YES, please list medication and explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)*

CURRENT PRESCRIPTION MEDICATION:

Name of drug; mg dose, # tablets, # times per day

_____

_____

_____

_____

_____

USE BACK SIDE (if needed)

OTC MEDICATION: Aspirin, Tylenol, Aleve, Vitamins (Herbals)

_____

_____

_____

_____

_____

USE BACK SIDE (if needed)

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
_____	_____
_____	_____

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

PATIENT/PARENT SIGNATURE: _____

Review of Symptoms

Are you currently experiencing any problems related to the following symptoms? 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: _____

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)

Screening Exams

Cholesterol	Colonoscopy	Mammogram	Pelvic Exam
PSA	Chest X-ray	Stress Test	Blood Pressure