Tahoe Forest Hospital Multispecialty Clinics

PATIENT HISTORY FORM

Your Name:____________________________________ Date: ______________________
Date of Birth: __________________
Who is your physician or provider sending you to us? Dr.________________________
What type of complaint or disease is the reason for requesting this visit?_______________

TELL US ABOUT YOURSELF:

Home situation (circle, or add in writing):

Single_____ Married (how long_____) Divorced (how long_____) Widowed (how long_____)

Domestic partnership_____ Children?_____ How many?__________Are they healthy?__________

Employment:

Occupation/type of work/jobs:____

Status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

Any toxic exposure? (if yes please explain)____

Habits: Do you smoke? No_____ Yes_____ If yes, how many packs per day?______________________
If yes, how many years?___________________________
If you have quit, how long ago?________________________

Do you use alcohol? No_____ Yes_____ If yes, how often do you drink?________________________
If you have quit, how long ago?________________________
Have you ever had problems with drug use?_______________

Nutrition: (Use a 0-5 scale to rate you consumption of the following foods: 0=Never consume 5=5 or more a day)
*Fatty Foods*_____ *Salt*_____ *Caffeine*_____ *Meat*_____ *Fish*_____ *Fruit*_____ *Vegetables*_____ *Fiber*_____ *Cheese*_____
*Highly processed foods*_____ *Calcium containing foods such as milk, yogurt,* _____ *Soy products*_____
Do you Exercise? No___ Yes___ If so what type and how often? ____________________________
How would you rate you stress level?_______________________

PAST MEDICAL HISTORY:

Past Surgeries	Approximate Date Done	Facility

Medical Problems (i.e., high blood pressure, diabetes, heart problems, etc.)

____
____
____

Date of last:
COLONOSCPY__________________ RECTAL EXAM______________ PAP SMEAR____________________
MAMMOGRAM__________________

MEDICATIONS:

Prescription medications	Dose	How often taken Daily	When did you start taking this medication?

NON-PRESCRIPTION (over-the-counter medications) such as aspirin, Tylenol, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken Daily	When did you start taking this medication?

ALLERGIES OR ADVERSE DRUG REACTIONS? (Please list drug and type of reaction)

____

____

FAMILY HISTORY:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member						
	Maternal Grandparent	Paternal Grandparent	Father	Mother	Sister	Brother	other
Cancer | Type:							
Stroke							
Heart disease							
Diabetes							
High blood pressure							
Liver disease							
High cholesterol							
Alcohol/drug abuse							
Depression/psychiatric illness							
Genetic (inherited) disorder							
Other							

Immunizations: (Check box and list date immunization was received)

☐ ☐ All Childhood Immunizations up-to-date

Pneumococcal Date: _______________

Influenza Date: _______________

Tetanus Date: _______________

SYMPTOM REVIEW(Check any items that apply to you)

Gastrointestinal

- ☐ Poor appetite
- ☐ Abdominal pain
- ☐ Indigestion
- ☐ Trouble swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Diverticulitis
- ☐ Hemorrhoids
- ☐ Nausea or vomiting
- ☐ Rectal bleeding, blood in stools, or other bleeding
- ☐ History of liver disease or abnormal liver tests
- ☐ Date of last colonoscopy______________
- ☐ Other:____________________________

Cardiovascular

- ☐ Chest pain
- ☐ Rapid or irregular heartbeat
- ☐ Rheumatic Fever
- ☐ Murmur
- ☐ Heart Attack
- ☐ Blockage of arteries
- ☐ Valve problems
- ☐ Enlarged heart
- ☐ Heart failure
- ☐ Ankle swelling
- ☐ Vein problems
- ☐ High blood pressure
- ☐ Blood clots
- ☐ Other:____________________________

Pulmonary/lungs

- ☐ Shortness of breath
- ☐ Persistent cough or sputum production
- ☐ Coughing up blood
- ☐ Asthma or wheezing
- ☐ Tb or pneumonia
- ☐ Other:____________________________

Muscle/joint/bone

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Soreness/weakness of muscles or joints
- ☐ Other:____________________________

Neurologic

- ☐ Headaches
- ☐ Seizures
- ☐ Double vision
- ☐ History of stroke
- ☐ Blackouts or loss of consciousness
- ☐ Trembling or shakiness
- ☐ Fainting or unsteadiness
- ☐ Numbness or loss of sensation
- ☐ Other:______________________________

General

- ☐ Anemia
- ☐ Weight gain/loss of 10+ lbs during last 6 months
- ☐ Poor sleep
- ☐ Fever
- ☐ Headache
- ☐ Depression or anxiety
- ☐ Suicidal preoccupation

Eyes, ears, nose, throat

- ☐ Persistent hoarseness
- ☐ Frequent earaches, sore throats, or sinusitis
- ☐ Bleeding from gums or nose
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Glaucoma or cataracts
- ☐ Other:____________________________

Skin

- ☐ Rashes
- ☐ Skin cancer
- ☐ Changing in moles or other spots
- ☐ Itching
- ☐ Eczema
- ☐ Non-healing sores
- ☐ Lumps
- ☐ Other:____________________________

Hormones and Metabolism

- ☐ History of diabetes
- ☐ Thyroid problems
- ☐ High cholesterol or other lipid problems
- ☐ What is your cholesterol?______________
- ☐ Other:____________________________

Genitourinary

- ☐ Infections
- ☐ Burning with urination
- ☐ Discharge
- ☐ Blood in urine
- ☐ Kidney disease or stones
- ☐ Leakage of urine
- ☐ Frequent urination
- ☐ Sexually Transmitted Diseases
- ☐ Other:______________________________

Women only

- ☐ Abnormal Pap smear
- ☐ Breast lumps
- ☐ Abnormal vaginal bleeding
- ☐ Date of last mammogram____________________
- ☐ Date of last Pap smear______________________

Men only

- ☐ Inadequate erections
- ☐ Slow stream
- ☐ Nighttime urination
- ☐ Do you check your testicles for lumps? ___________