Drs. Louapre, Kokemor, Sarrat & Braedt, L.L.C.

PATIENT HISTORY FORM

Today'sDate:_____________Name:____________________________________

Date of Birth_____________Occupation:____________________________

Date of last physical exam:______________

Please list the names of other providers from whom you have received care in the past year (including physicians, chiropractors, counselors, acupuncturists, naturopaths, or psychiatrists):

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What is the main reason for your visit today? (Explain specific symptoms, how they started and what happened).

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Past Medical History:

Do you have, or have you had in the past, any of the following conditions: (please circle)

Anxiety	Heart Disease	Rheumatoid Arthritis
Asthma	Hepatitis	Seizure Disorder
Depression	High Blood Pressure	Stroke
Diabetes	High Cholesterol	Thyroid Disease
GERD	Kidney Disease	Tuberculosis
Heart AttackOsteoporosis		STD

Cancer Type____

Please list any prior injuries and the date of injury:____________________________

Surgical History: Please list nay surgeries you have had with the dates performed:

________________ ______________________ ___________________

________________ ______________________ ___________________

Medications:

Please list any prescription or over the counter medications you take (including vitamins) and the dose:

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Allergies:

Have you ever had a reaction to any medications? If so, which medication and what happened?____

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Are you on a special diet? If yes, please explain.

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Family History:

Are there any illnesses such as cancer, diabetes, heart disease, Kidney disease or depression that run in your family? Y or N

Health status of your family:

Relationship:	Living:	Age:
Mother	Y N	_____
Father	Y N	_____
Sibling	Y N	_____
Sibling	Y N	_____
Paternal Grandfather	Y N	_____
Paternal Grandmother	Y N	_____
Maternal Grandfather	Y N	_____
Maternal Grandmother	Y N	_____
Children	Y N	______ _______ ______ ______ ______

Do you:

Currently smoke tobacco? Y N If yes, how much? _________ How long? _______

Past smoker? Y N Last quit date: __________

Drink alcohol? Y N If yes how much? ___________

Use recreational or "street drugs" (including marijuana, cocaine, LSD, ecstasy, methamphetamine) Y N

Exercise regularly? Y N

Travel outside the U.S.? Y N

<u>Have you</u>:

Had a tetanus shot in the last 10 years? Y N

Ever had a pneumonia vaccine? Y N

Ever had a flu shot? Y N

Been tested for colon cancer? Y N

Women

Date of last PaP smear? ____________ Last Mammogram?_______________________

Date of last menstrual period? ____________Is your period predictable?__________________

Birth control method____

Number of pregnancies: _______ Number of births______________ Any miscarriages? _________

Review of Systems

Please circle any of these that apply to you or write in any that are not listed

General: fever, chills, night sweats, fatigue, weakness, weight loss, sleep disorder, anxiety, anger, sadness, poor concentration

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Eyes: blurred vision, double vision, irritation, eye pain, vision loss, wear glasses or contacts

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Ears, Nose, Throat: ear pain, popping, ringing in ears, decreased hearing, nasal congestion, nose bleeds, sore throat, hoarseness, snoring, wax in ears

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Cardiovascular: chest pain, palpitations, light headedness, shortness of breath with walking, difficulty sleeping flat, heart disease, leg or ankle swelling

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Respiratory: cough, shortness of breath at rest, excessive phlegm, bloody phlegm, wheezing, chest pain with deep breath, asthma

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Gastrointestinal: nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, blood inn stool, blood in vomit, jaundice, gas, bloating, indigestion/heartburn, difficulty swallowing, ulcers, hernia____

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For Men: painful urination, blood in urine, penile discharge, urinary frequency, urinary hesitancy, abnormal urine stream, waking frequently to urinate, lose urine with cough or straining, testicular pain or swelling, difficulty achieving or maintaining an erections, pain with ejaculation, premature ejaculation, history of sexually transmitted disease____

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For Women: vaginal discharge, lose urine with cough or straining, painful urination, blood in urine, urinary frequency, heavy cycles, irregular cycles pain with menses, pain or bleeding with intercourse, history of abnormal pap smear, history of sexually transmitted disease

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Muscles and Joints: back pain, joint pain, joint swelling, muscle cramps or pain, muscle weakness, arthritis, fractures, dislocations, sprains, cold or blue fingers and toes____

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Skin: rash, itching, dryness, moles, acne, flaky scalp, skin cancer____

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Neurologic: burning or tingling, seizures, tremors, dizziness, fainting spells, blurry vision, frequent falls, frequent headaches, difficulty walking, memory loss

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Psychological: depression, anxiety, memory loss, phobias, confusion

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Endocrine: cold intolerance, heat intolerance, excessive thirst, excessive urination, unusual weight change ____

Blood: Abnormal bruising, abnormal bleeding, anemia, enlarged or swollen glands

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Allergy: itching hay fever, rashes____