

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

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

USE BACK SIDE (if needed)

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 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 _____