Capital Medical Clinic, LLP
Patient Health History Form
(Please fill out front and back) **Date**____________

Personal Information

Last Name: First Name:
Birth Name: DOB: / /
Emergency Contact:
Contacts Phone:
Power of Attorney (name):
DNR Status (do not resuscitate):
Do you have a living will?
Marital Status?
Occupation: Present:
Past:

Whom may we thank for this referral?

Name:
Address:

Tobacco Use: per/day

Age you started: Age you quit:
Cigarettes:
Other:

Alcohol intake per/week

Beer: Mixed drinks:

Family Medical History
(Cancer, heart problems, diabetes)

	Name	Age	History
Mother:			
Father:			
Grandparents:			
Children:			
Siblings:			

Please give a short explanation of your illnesses/symptoms concerning the following body systems:

Head

Headache
Seizures
Wear glasses, contacts
Hearing problems
Sinus problems/allergies
Dentures

Heart and Blood Vessels

High blood pressure
Heart attack or heart disease
Strokes
Blood clots
Phlebitis
Anemia
What is your cholesterol?

Chest

Asthma
Bronchitis/emphysema

Stomach & Intestinal

Indigestion, constipation or diarrhea
Gallstones
Hepatitis
Blood in stools/change in bowel habits

Genital & Urinary

Bladder infection
Kidney stones
Sexually transmitted disease
Prostate problems (men only)
Incontinence

For Women

Are you periods regular?
When was your last period?
When was your last pap smear?
Pregnancies: Live births:
When was your last mammogram?

Bones, Joints, Muscles

Arthritis
Muscle weakness
Broken bones

Psychiatric

Anxiety or depression
Any other psychiatric problems?
Ever consider, attempt suicide?
Hospitalized for psychiatric problem?
Appetite?
Sleep well?

General

Diabetes
Thyroid problems
Tuberculosis
Recent weight change
Date of last tetanus shot
Date of last Pneumovax:
Date of last Flu Vaccine:

Any major changes in your life in the last year?
(Births, deaths, moves, job changes)

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List all Hospitalizations and Surgeries	
Date	**Reason**

Please list any other information you would like your physician to know
Name:

Current Medications (Include over-the-counter & vitamins)

Medical allergies
Medications:
Other (seasonal, foods):
D.O.B.: