Patient History Form

Please complete the form prior to your appointment. Once completed either send to us via the Spruce App or bring to your first appointment.

Full Name: Date of Birth:

Date:

Tell us about yourself:

Home situation (circle, or add in writing):

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

Domestic partnership_____ Children _____ Are they healthy? _____

Employment:

Status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

Occupation:

type of work/jobs:_____

Habits:

Do you smoke? No_____ Yes_____ If yes, how many packs per day?_____
If you have quit, how long ago?_____

Do you use other tobacco products? No _____ Yes_____ If so, which products? _____

Do you use alcohol? No_____ Yes_____ If yes, how often do you drink?_____
If you have quit, how long ago?_____
Do family or friends worry about your alcohol intake? _____

Do you use illicit drugs? No_____ Yes_____ If yes, please specify _____

Nutrition Habits:

1. How would you describe your eating habits?

2. Would you like to increase or decrease your weight?

3. Are you on a special diet (diabetic, low fat, vegetarian, etc.?)

Exercise Habits:

1. Do you exercise on a regular basis? (3 or more times/week for 20-30 minutes or more)

2. What type of exercise do you do?

3. If you do not exercise is it due to a particular reason (physical limitations, job, family life, etc.?)

Psycho/Social:

1. Do you feel like your life has a purpose?

2. How would you describe your overall mood?

3. Are you or have you undergone any major issues/stresses in your life?

4. If yes, how do you cope with these issues or stressors?

Allergies or Adverse Drug Reactions:
Please list drug and type of reaction

Past Medical History:
Please list other diseases from which you <u>currently</u> suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the past:

Surgical History:
Please list any surgeries (operations), reason for the surgery, and the date of the surgery:

Medications:

Prescription medications	Dose	How often taken

Non-prescription /Supplements (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

Family History:

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

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

Do you have Health Care Surrogate/Health Care Directives? (If yes, please provide a copy at your first visit)

Immunizations: if YES, give approximate year given

Pneumococcal No_____ Yes_____
Hepatitis A No_____ Yes_____
Hepatitis B No_____ Yes_____
Tetanus No_____ Yes_____
Shingles No_____ Yes_____
HPV Vaccine No_____ Yes_____

Safety:

Do you use seatbelts? No_____ Yes_____

Transfusions:

Have you ever received a blood transfusion? No_____ Yes_____ When?_____

Please mark any symptoms you are currently experiencing or have experienced in the last month:

SYMPTOM REVIEW

Gastrointestinal

□ poor appetite
□ abdominal pain
□ indigestion
□ trouble swallowing
□ diarrhea
□ constipation
□ change in bowel habits
□ nausea or vomiting
□ rectal bleeding or blood in stools
□ history of liver disease or abnormal liver tests

Cardiovascular

□ chest pain
□ history of angina or heart attack
□ history of high blood pressure
□ history of irregular beat
□ history of poor circulation

Pulmonary/lungs

□ shortness of breath
□ persistent cough
□ coughing up blood
□ asthma or wheezing

Muscle/joint/bone

□ swelling of ankles or legs

pain, weakness or numbness in

□ arms or hands
□ back or hips
□ legs or feet
□ neck or shoulders

Neurologic

□ history of stroke
□ blackouts or loss of consciousness

General

□ weight gain/loss of 10+ lbs during last 6 months
□ poor sleep
□ fever
□ headache
□ depression

Eyes, ears, nose, throat

□ blurred vision
□ other change in vision
□ history of glaucoma or cataracts
□ loss of hearing
□ ringing in ears
□ sinus problems
□ hoarseness

Genitourinary

□ frequent or painful urination
□ blood in urine

Skin

□ itching
□ easy bruising
□ change in moles

Endocrine

□ history of diabetes
□ history of thyroid disease
□ change in tolerance to hot or cold weather
□ excessive thirst

Women only

□ abnormal Pap smear
□ bleeding between periods

date of last mammogram_____

Men only

□ PSA

Anything else?

□ Are you experiencing an unusually stressful situation?

□ Are there any specific personal issues you would like to bring up at the time of your visit?

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT