

PATIENT HISTORY FORM

for Dr. Charlotte B. Alexander, MD

Name: _____ Date: _____

Occupation: _____ Age: _____ Sex: male female

Student? yes no School: _____ Sports: _____

HISTORY OF INJURY

Auto accident? yes no Work accident? yes no Other accident? yes no

Date of onset: _____ Left Right

Reason for today's visit: _____

Have you sought medical attention for this problem? yes no

If yes, from whom: _____

What treatment was given? _____

PAST HISTORY

List all current medications, herbals, diet, vitamins, over the counter, etc. (If you need more space, please use the back of this sheet)

MEDICATION	DOSAGE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking a blood thinner? yes no (Coumadin Plavix Lovenox Aspirin other)

List allergies to medications or check None: _____

List all illnesses or check None:

- Anemia
- Anxiety
- Arthritis
- Asthma
- Bleeding disorder
- Blood clots
- Cancer _____
- Chemotherapy
- Depression
- Diabetes I
- Diabetes II
- Dialysis
- Emphysema
- GI bleed
- Heart attack
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High blood pressure
- Other please explain: _____
- High cholesterol
- HIV
- Irregular heart beat
- Kidney disease
- Kidney stones
- Mitral valve prolapse
- Osteoporosis
- Poor circulation
- Pulmonary embolism
- Reflux
- Rheumatoid
- Seizures
- Sleep apnea
- Staph infections
- Strokes
- Thyroid disease
- Tuberculosis
- Ulcers

Name: _____

PAST HISTORY (continued)

List all operations with dates or check None:

- | | | | |
|---|--|-----------------------------------|---|
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Arm | <input type="checkbox"/> Cardiac bypass |
| <input type="checkbox"/> Cardiac stents | <input type="checkbox"/> Colon surgery | <input type="checkbox"/> Elbow | <input type="checkbox"/> Fingers |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hand | <input type="checkbox"/> Hernia repair |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Knee | <input type="checkbox"/> Leg |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Spine back |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> Other please explain: _____ | | |

Have you had a general anesthetic? yes no Any problems? _____

Transfusions: yes no Any problems? _____

Hospitalizations other than surgery yes no Any problems? _____

FAMILY HISTORY

	Age	Living/Deceased	Arthritis	Illnesses/Cause of Death
Mother:	_____	_____	_____	_____
Father:	_____	_____	_____	_____
Brother(s):	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____
Child(ren):	_____	_____	_____	_____

SOCIAL HISTORY

Marital status: single married divorced widowed

Occupation: _____

Work duties: physical sedentary retired homemaker student heavy labor

Have you had a fall in the last year? yes no Explain: _____

Do you live alone? yes no Do you need assistance? _____

Are you the caretaker for an elderly family member? yes no

Have you had a bone density test? yes no

What were the results of the bone density? _____

When and what were the results? _____

Are you taking medication for osteoporosis? yes no

Actonel Fosamax Vitamin D | Calcium Boniva Forteo other _____

RISK FACTORS

Tobacco: yes no (cigarettes cigars chewing tobacco pipe nicotine patches nicotine gum)

Packs | Cigars | Pipes per day: _____ Number of years: _____

Stopped tobacco use: _____ Number of years used: _____

Name: _____

RISK FACTORS (continued)

Alcohol: no occasionally daily Drinks per day: _____

History of alcoholism: yes no Explain: _____

Substance | drug abuse: yes no Explain: _____

Pain medication abuse: yes no Explain: _____

Exercise: daily weekly monthly rarely never

Type of exercise: _____

Sports played: _____

REVIEW OF SYSTEMS (please check all that apply)

General

- Weight loss
- Weight gain
- Chills
- Fevers
- Night sweats

Skin

- Rash
- Lesions
- Infections
- Staph
- Other

HEENT

- Hay fever
- Postnasal discharge
- Hoarseness
- Visual Problems
- Hearing Problems

Cardiovascular

- Chest pain (angina)
- Palpitations (rapid heartbeat)
- Irregular heartbeat (arrhythmia)
- Rheumatic fever
- Swollen ankles (pedal edema)

Pulmonary

- Shortness of breath
- Wheezing
- Coughing
- Coughing up blood (hemoptysis)

Genitourinary

- Frequent urination (frequency)
- Urgent urination (urgency)
- Painful urination (dysuria)
- Need to urinate at night (nocturia)
- Blood in urine (hematuria)
- Penile or vaginal discharge
- Kidney stone pain (renal colic)

Gastrointestinal

- Indigestion
- Nausea
- Vomiting
- Vomiting blood (hematemesis)
- Yellow skin
- Abdominal pain
- Constipation
- Diarrhea
- Black stools (melena)
- Rectal bleeding

Musculoskeletal system

- Joint Pain
- Stiffness
- Swelling
- Numbness | Tingling
- Fractures | Dislocations

Psychiatric

- Anxiety
- Depression
- Other _____

Lymphatics

- Lymph node swelling
- Node tenderness

Endocrine

- Excessive urination (polyuria)
- Excessive thirst (polydipsia)
- Excessive appetite polyphagia)
- Heat intolerance
- Cold intolerance

Musculoskeletal

- Joint surgery

Tumors or Masses

- Cysts

Neurological

- Loss of consciousness
- Headaches
- Dizziness
- Seizures (fits)
- Fainting spells

Females

Are you pregnant? yes no
Date of last menstrual cycle: _____

Pharmacy Name

Pharmacy Address

Pharmacy Phone Number

Height: _____ Weight: _____ Dominance: right hand left hand

Signature: _____ Date: _____

I certify that the information provided above is correct and true.