*Dan B. Stephens, MD, FACOG*

# Patient History

Patient Name:______________________________ Date:______________

Describe your main problem ____________________________________________

How long have you had this problem?________________________________

When does this problem occur?________________________________

How severe is your problem? ________________________________

What other things happen with this problem?________________________________

________________________________________________

What makes this problem worse or better? ________________________________

________________________________________________

List previous hospitalizations/Surgeries/Serious Injuries | When?

____________________________________ ______________

____________________________________ ______________

____________________________________ ______________

____________________________________ ______________

____________________________________ ______________

____________________________________ ______________

Patient Social History

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Sexual Activity ❑ One Partner ❑ Multiple Partners

❑ Birth Control Method ______________________

Use of alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily ____________

Use of tobacco: ❑ Never ❑ Previously but quit ❑ Current packs per day _____

Use of Drugs: ❑ Never ❑ Type/Frequency______________________

Excessive exposure at home or work to: ❑ Fumes ❑ Dust ❑ Solvents ❑ Noise

**Have you ever had the following?**

| | | |
|---|---|---|
| Diabetes.................. | yes | no |
| Hypertension............ | yes | no |
| Cancer.................... | yes | no |
| Thyroid Dysfunction....... | yes | no |
| Heart trouble............. | yes | no |
| Rheumatic Fever.......... | yes | no |
| Kidney Disease............ | yes | no |
| Bleeding tendency........ | yes | no |
| Acute infections........... | yes | no |
| Venereal disease.......... | yes | no |
| Hereditary defects......... | yes | no |
| Hysterectomy ............. | yes | no |

List Medications you are currently taking

1)______________________

2)______________________

3)______________________

4)______________________

5)______________________

6)______________________

7)______________________

8)______________________

9)______________________

10)______________________

Family Medical History

| | Age | Diseases | If Deceased, Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |
| Spouse | | | |
| Children | | | |
| | | | |
| | | | |
| | | | |

## PLEASE ANSWER ALL QUESTIONS

***Have you had any of the following during the past three months?***

**CONSTITUTIONAL**

Good general health lately........................... No Yes
Recent weight change................................ No Yes
Fever................................................ No Yes
Fatigue.............................................. No Yes
Headaches............................................ No Yes

**GENITOURINARY**

Frequent urination.................................... No Yes
Burning or painful urination......................... No Yes
Blood in urine....................................... No Yes
Change of force of strain when urinating......... No Yes
Incontinence or dribbling............................ No Yes
Change of force of strain when urinating......... No Yes
Do you use birth control?........................... No Yes
Sexual difficulty..................................... No Yes
Date of last menstrual period _____/_____/_____
Are you past your menopause?...................... No Yes
Have you had a hysterectomy?..................... No Yes
Pain with periods.................................... No Yes
Irregular periods..................................... No Yes
Last menstrual period normal....................... No Yes
Heavy bleeding with periods ........................ No Yes
Bleeding between periods .......................... No Yes
Bleeding after intercourse .......................... No Yes
Vaginal itching or discharge... ........ ..............No Yes
Breast pain........................................... No Yes
Breast lump........................................... No Yes
Breast discharge..................................... No Yes
# of full term births ______ # of premature births _____
#of miscarriages ______ # of abortions _____
# of living children ___________
Date of last pap smear _____/_____/_____
Findings of last pap smear ❑ Normal ❑ Abnormal

**GASTROINTESTINAL**

Loss of appetite...................................... No Yes
Change in bowel movements....................... No Yes
Nausea or vomiting.................................. No Yes
Frequent diarrhea.................................... No Yes
Painful bowel movements or constipation........ No Yes
Blood in stool........................................ No Yes
Stomach pain......................................... No Yes

**EYES**

Wear glasses/contact lens.......................... No Yes

**ENT**

Earaches or drainage................................ No Yes
Sinus problems....................................... No Yes
Swollen glands in neck............................. No Yes

**CARDIOVASCULAR**

Chest pains........................................... No Yes
Sudden heart beat changes.......................... No Yes
Swelling of feet, ankles or hands.................. No Yes

**RESPIRATORY**

Spitting up blood.................................... No Yes
Shortness of breath.................................. No Yes
Asthma or wheezing................................. No Yes

**MUSCULOSKELETAL**

Joint pain............................................. No Yes
Muscle pain or cramps.............................. No Yes
Back pain............................................. No Yes
Cold extremities..................................... No Yes

**SKIN**

Rash or itching ...................................... No Yes
Change in skin color................................. No Yes
Varicose veins....................................... No Yes

**NEUROLOGICAL**

Frequent or recurring headaches.................... No Yes
Light headed or dizzy............................... No Yes
Head injury........................................... No Yes

**PSYCHIATRIC**

Nervousness.......................................... No Yes
Depression............................................ No Yes

**ENDOCRINE**

Hormone problem.................................... No Yes
Thyroid disease...................................... No Yes
Excessive thirst or urination........................ No Yes
Heat or cold intolerance............................ No Yes

**HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts.............................. No Yes
Easily bruise or bleed............................... No Yes
Anemia................................................ No Yes
Past transfusion...................................... No Yes

**ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other adverse reactions to:
Penicillin or other antibiotics............ No Yes
Morphine, Demerol or other narcotics.. No Yes
Novocaine or other anesthetics.......... No Yes
Tetanus antitoxin or other serums...... No Yes
Iodine, methiolate or other antiseptic... No Yes
Other drugs/medications ___________________________
Known food allergies ______________________________

Patient Signature: ________________________________ Physician Signature: ________________________________