Holy Cross Hospital

PATIENT HISTORY FORM

Date: ____________

Patient's Name: ______________________ Birthdate: ____________

Reason for Visit: ______________________

It is helpful to gather information about your medical history for the physician to use in your examination. Please complete this form completely for the physician's review.

CONSTITUTIONAL SYMPTOMS

- Good general health lately ☐ No ☐ Yes
- Recent weight change ☐ No ☐ Yes
- Fever ☐ No ☐ Yes
- Fatigue ☐ No ☐ Yes
- Exercise regularly ☐ No ☐ Yes
- Eat a balanced diet ☐ No ☐ Yes

EYES

- Eye disease or injury ☐ No ☐ Yes
- Wear glasses/contact lenses ☐ No ☐ Yes
- Blurred or double vision ☐ No ☐ Yes
- Glaucoma ☐ No ☐ Yes

EARS/NOSE/THROAT

- Hearing loss or ringing ☐ No ☐ Yes
- Earaches or drainage ☐ No ☐ Yes
- Chronic sinus problem or rhinitis ☐ No ☐ Yes
- Nose bleeds ☐ No ☐ Yes
- Mouth sores ☐ No ☐ Yes
- Bleeding gums ☐ No ☐ Yes
- Sore throat or voice change ☐ No ☐ Yes

CARDIOVASCULAR

- Heart trouble ☐ No ☐ Yes
- Chest pain or angina pectoris ☐ No ☐ Yes
- Palpitation ☐ No ☐ Yes
- Shortness of breath with walking ☐ No ☐ Yes
- Swelling of feet, ankles or hands ☐ No ☐ Yes
- Murmur ☐ No ☐ Yes
- Mitral valve prolapse ☐ No ☐ Yes

RESPIRATORY

- Chronic or frequent coughs ☐ No ☐ Yes
- Spitting up blood ☐ No ☐ Yes
- Shortness of breath ☐ No ☐ Yes
- Asthma or wheezing ☐ No ☐ Yes

GASTROINTESTINAL

- Loss of appetite ☐ No ☐ Yes
- Change in bowel movements ☐ No ☐ Yes
- Nausea or vomiting ☐ No ☐ Yes
- Frequent diarrhea ☐ No ☐ Yes
- Constipation ☐ No ☐ Yes
- Rectal bleeding or blood in stool ☐ No ☐ Yes
- Abdominal pain ☐ No ☐ Yes
- Peptic ulcer (stomach or duodenal) ☐ No ☐ Yes
- Reflux ☐ No ☐ Yes

MUSCULOSKELETAL

- Joint pain ☐ No ☐ Yes
- Joint stiffness or swelling ☐ No ☐ Yes
- Weakness of muscles or joints ☐ No ☐ Yes
- Muscle pain or cramps ☐ No ☐ Yes
- Back pain ☐ No ☐ Yes
- Cold extremities ☐ No ☐ Yes
- Difficulty in walking ☐ No ☐ Yes
- Sports injury ☐ No ☐ Yes

INTEGUMENTARY (SKIN, BREAST)

- Rash or itching ☐ No ☐ Yes
- Change in skin color ☐ No ☐ Yes
- Change in hair or nails ☐ No ☐ Yes
- Varicose veins ☐ No ☐ Yes
- Breast pain ☐ No ☐ Yes
- Breast lump ☐ No ☐ Yes
- Breast discharge ☐ No ☐ Yes
- Changing mole ☐ No ☐ Yes

NEUROLOGICAL

- Frequent or recurring headaches ☐ No ☐ Yes
- Light headed or dizzy ☐ No ☐ Yes
- Convulsions or seizures ☐ No ☐ Yes
- Numbness or tingling sensations ☐ No ☐ Yes
- Tremors ☐ No ☐ Yes
- Paralysis ☐ No ☐ Yes
- Stroke ☐ No ☐ Yes
- Head injury ☐ No ☐ Yes

PSYCHIATRIC

- Memory loss or confusion ☐ No ☐ Yes
- Nervousness ☐ No ☐ Yes
- Depression ☐ No ☐ Yes
- Insomnia ☐ No ☐ Yes

ENDOCRINE

- Glandular or hormone problem ☐ No ☐ Yes
- Thyroid disease ☐ No ☐ Yes
- Diabetes ☐ No ☐ Yes

  (Insulin or non insulin – circle one)
- Excessive thirst or urination ☐ No ☐ Yes
- Heat or cold intolerance ☐ No ☐ Yes
- Skin becoming dryer ☐ No ☐ Yes
- Change in hat or glove size ☐ No ☐ Yes

GENITOURINARY

Frequent urination ❑ No ❑ Yes
Burning or painful urination ❑ No ❑ Yes
Blood in urine ❑ No ❑ Yes
Incontinence or dribbling ❑ No ❑ Yes
Kidney stones ❑ No ❑ Yes
Sexual difficulty ❑ No ❑ Yes
Pain with periods ❑ No ❑ Yes
Use douche ❑ No ❑ Yes
Irregular periods ❑ No ❑ Yes
Vaginal discharge ❑ No ❑ Yes
Age at the onset of menstruation: ______
Number of days menstruation lasts: ______
Date of last PAP smear: ______
Date of last menstrual period: ______
Date before that: ______
Age at first intercourse: ______
Date of last mammogram: ______

History of vaginal/pelvic infection ❑ No ❑ Yes
Number of pads or tampons per day: ______

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts ❑ No ❑ Yes
Bleeding or bruising tendency ❑ No ❑ Yes
Anemia ❑ No ❑ Yes
Phlebitis ❑ No ❑ Yes
Past transfusion ❑ No ❑ Yes
Enlarged glands ❑ No ❑ Yes

ALLERGIC/IMMUNOLOGIC

Allergic to medications ❑ No ❑ Yes
(If yes, please list)

______

FORM OF BIRTH CONTROL: ______

List all pregnancies with dates, weights and problems (Please include miscarriages, terminations and pre-term:

______

PAST MEDICAL HISTORY

Previous hospitalizations/surgeries/serious injuries: ______

Medications: ______

PATIENT SOCIAL HISTORY

Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Use of alcohol: ❑ Never Number per week: ______
Use of tobacco: ❑ Never ❑ Previously quit – Date quit: ______ ❑ Current packs per day: ______
Use of drugs: ❑ Never ❑ Type/frequency: ______
History of: ❑ Sexual assault: ______ ❑ Domestic violence: ______

FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father:			
Mother:			
Siblings:			
Children:			
Other blood relatives:			

Do you wish to have an assistant present during your exam?: ❑ No ❑ Yes

Patient Signature: ______

Physician reviewed: ______ **Date:** ______

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