# *GANT* PATIENT HISTORY FORM (TO BE COMPLETED BEFORE VISIT/CONSULTATION)

**Name:** ________________________________________
First Middle Last

DATE: _______________ Birth Date: __________________

SS #: ___________________ VERSION OCT 2008

**Your age:** _________

***WHY ARE YOU SEEING THE DOCTOR TODAY?*** ____________________________________________________________

______________________________________________________________________________________

**Doctor requesting Consultation:** ___________________________________ **PCP if different from this Dr:**____________________

**Habits, Social History (Answer, or circle if item is applicable to your history)**

Occupation_____________________ Marital: Married Divorced Widow Single Children (#): _________
Do you smoke? Yes No _________ Do you use other forms of tobacco? Yes No ____________
Do you drink alcohol? Yes No Amount per day/week __________________
If sexually active with more than one partner, do you use "safe sex practices?" Yes No Not Applicable
Have you ever used IV Drugs? Yes No If "Yes", have you had tests for: AIDS Hepatitis B Hepatitis C
Circle the immunizations or vaccinations you have had: Hepatitis B <> Hepatitis A <> Influenza <> Pneumonia

**Past History – Surgical (Circle if you have had any of the following)**

| | | | |
|---|---|---|---|
| Appendix removed | Ulcer Surgery | Heart Surgery Bypass | Other Surgery_____________ |
| Gallbladder Removed | Colon Surgery | Heart Valve Surgery | Anesthesia problems |
| Hiatal Hernia Surgery | Hemorrhoid Surgery | Pacemaker | Blood Transfusions (dates______) |
| Groin Hernia Surgery | Prostate Surgery | Automatic Defibrillator | Blood Donation (dates _________) |
| Other Hernia Surgery | Joint Replacement | Uterus Removal (hysterectomy)(ovaries removed or ovary(ies) remain) | |

**Past History - NonSurgical (Circle if you have or have had the following)**

| | | | |
|---|---|---|---|
| Hiatal Hernia | Crohn's Disease | Anemia | Asthma |
| Reflux (GERD) | Ulcerative Colitis | Heart disease (angina, heart attack) | Bleeding Problems |
| Ulcers (Peptic) | Diverticulosis | High Blood Pressure | Diabetes |
| Gallstones | Colon Polyps | Stroke/ T.I.A. | Thyroid Problems |
| Other Liver Problems | Irritable Bowel | Kidney disease/stones | Rheumatic Fever |
| Hepatitis (any type) | Cancer (type________) | Emphysema | Seizure disorder |
| Cholesterol problems | Prostate problems | Sleep apnea | Other ________________ |

**Family Medical History (Has ANYONE in your immediate family (Mother/Father/Bro-Sis) has had any of the following):**

Cancer of Colon/Rectum/Small intestine /Stomach /Pancreas /Liver /Breast /Uterus /Ovary/Kidney/ Other:______________

| | | | |
|---|---|---|---|
| Colon Polyps | Gallstones | Pancreatitis | Peptic Ulcer |
| Crohns Disease | Ulcerative Colitis | Liver disease | Heart disease |

**Family History (circle applicable or briefly answer)**

Your Mother: Living / Deceased Current health or cause of death/age:________________________________________
Your Father: Living / Deceased Current health or cause of death/age:________________________________________
Sisters # _______ # Living ____ # Deceased ____ Health/cause of death/age: ______________________________
Brothers # ______ # Living ____ # Deceased ____ Health/cause of death age: ______________________________

**List all prescription and non-prescription medicines you take on a regular or frequent basis)**
**(The nurse will go over with you the doses and the schedule you take these on)**

| | | | |
|---|---|---|---|
| 1. | 4. | 7. | MEDICINE ALLERGIES? List ⇓ |
| 2. | 5. | 8. | |
| 3. | 6. | 9. | |

Do you use "Non Steroidal Anti-inflammatory Drugs" (Aspirin, Advil, Ibuprofen, and Aleve) regularly? Yes / No
Do you use any Herbal Products/Health Food Store Products? Yes / No If yes, please list:

**SYSTEM REVIEW (fill in the blank, or circle symptoms/conditions you have)**

GENERAL: Weight gain Weight loss
Feeling tired Feeling poorly Fever/Chills

HEART: Chest pain/angina Palpitations
Slow or fast heart rate Leg pain with exertion

LUNGS/PULMONARY: Cough Shortness of breath
Shortness of breath with exertion Wheezing/asthma
Shortness of breath lying down or sleeping

GENITOURINARY: Pain with urination Incontinence
WOMEN: Last period: _____ Pelvic pain or pain during menses
Vaginal discharge Abnormal vaginal bleeding
MEN: Hesitancy Genital lesions
Frequent nighttime urination Testicle pain

MUSCULOSKELETAL: Joint pain Joint swelling
Joint stiffness Arm/leg pain Arm/leg swelling

HEME: Abnormal Bleeding Abnormal Bruising
Swollen glands Anemia in past

ENDOCRINE: Muscle weakness Hot flashes
Voice deepening Eye bulging General weakness

EYES: Eye pain Dry eyes Red eyes
Eye drainage Itchy eyes Eyesight problems

ENT: Earache Bloody nose Nasal discharge
Sore throat Hearing loss Hoarseness

GI: Loss of appetite Heartburn Indigestion
Difficulty Swallowing Frequent Vomiting
Frequent nausea Pain in Abdomen
Change in bowel habits Diarrhea
Constipation Blood in stools

SKIN: Skin lesions Itching Skin wound
Breast pain Breast mass Change in a mole

NEURO: Convulsions Headache
Confusion Dizziness Fainting
Difficulty walking Limb weakness

PSYCH: Anxiety Depression Bipolar disease
Suicidal thoughts Sleep disturbance
Personality change Emotional problems

______________________________
**Patient signature**

______________________________
**Patient Name (please print)**

***⇓PLEASE DO NOT WRITE BELOW THIS LINE⇓***

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**PHYSICAL EXAMINATION:** (to be completed by office personnel)

**Vital Signs:** **Wt:** _______ **BP:** _________ **Pulse:** ________ **Temp:** ________ **Appearance:** ________

**Skin:** insp/palpate:

**Lymphatic:** Neck/axillae/groin/other

**HEENT:** Eyes-conj/pupils Ears / Oropharynx

**Neck:** Supple/thyroid

**Chest:** Effort/perc/auscul:

**Heart:** Ausc/carotids/AAA/Fem art/edema:

**Abdomen:** Mass/L-S/Hernia/Ascites**:**

**Rectal:** Tone/mass/hemorr/guaiac/prostate**:**

**Neurological:** Cranial nerves, DTR, Gait

**Musculoskeletal:** Edema, Swelling, ROM

**Psychiatric:** Judgment, affect, orientation,

**Lab tests w/ Dates:**

**X-ray Review:** facility dates**:**

**Old Records Review Source:**

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**Assessment(s):**

**1.**

**2.**

**3.**

**4.**

**Plan:**

**1. Diagnostic:**

**2. Therapeutic:**

**3. Educational:**

**4. Other:**

______________________________
**Doctor's Signature / Date:**

______________________________
**Dictated / Date: Other:**