**PATIENT HISTORY FORM**

**Carter Medical Clinic**

1015 E. Broadway, Suite 102

P.O. Box 575

Altus, OK 73522-0575

580 480-1600

580 480-1601 fax

“Healthcare for the community by people who care.”

**(PHF)**

**GENERAL INFORMATION**

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_

A. **Chief Complaints** (Why you came to see the doctor today.) List each problem and when it started:

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 **Associated Symptoms** (Problems which you think are related to your chief complaints.)

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**PAST MEDICAL HISTORY**

B. **Review of Systems** (Problem you currently have or have been diagnosed with in the past)

 Please mark all boxes (No/Yes) and add details in blanks.

**1) Constitutional**

No Yes

o o Weight Loss / Gain\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Chronic Fever\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Anesthetic Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Birth Complications\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Childhood Illness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2) Eyes**

No Yes

o o Visual Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Double Vision\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3) Head/Ear Nose and Throat**

No Yes

o o Ear Infections\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Ear Pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Hearing Loss\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Ringing in Ears\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Ear Drainage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Dizziness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Sinus Infections\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Smell & Taste Disorder\_\_\_\_\_\_\_\_\_\_

o o Nasal Obstruction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Nasal Polyps\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

o o Nose Bleeds\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Dental Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o TMJ Syndrome\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Hoarseness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Swallowing Problems\_\_\_\_\_\_\_\_\_\_\_\_

o o Neck Mass/Swelling\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Snoring/Apnea\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4) Cardiovascular**

No Yes

o o Rheumatic Fever\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Heart Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Strokes/TIA’s\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Irregular Heart Beat\_\_\_\_\_\_\_\_\_\_\_\_\_

o o High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_

o o Chest Pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5) Respiratory**

No Yes

o o Chronic Cough\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o COPD / Asthma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Shortness of Breath\_\_\_\_\_\_\_\_\_\_\_\_\_

**6) Gastrointestinal**

No Yes

o o Stomach Ulcers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Heartburn / Acid Reflux\_\_\_\_\_\_\_\_\_

o o Hepatitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Hiatal Hernia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Food Sensitivity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7) Genitourinary**

No Yes

o o Kidney Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Kidney Infection\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8) Musculoskeletal**

No Yes

o o Muscle / Joint Pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Back / Neck Pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9) Integument**

No Yes

o o Skin Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Skin Lesion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o MRSA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10) Neurologic**

No Yes

o o Head Injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Seizures\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Headaches\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Loss of Consiousness\_\_\_\_\_\_\_\_\_\_\_\_

**11) Psychiatric**

No Yes

o o Emotional Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Attention Deficit Disorder\_\_\_\_\_\_\_\_

o o PTSD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12) Endocrine**

No Yes

o o Diabetes\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Thyroid Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13) Hematologic - Lymphatic**

No Yes

o o Easy Bleeding / Bruising\_\_\_\_\_\_\_\_\_

o o Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Enlarged Lymph Nodes\_\_\_\_\_\_\_\_\_\_

o o Blood Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14) Allergic-Immunologic**

No Yes

o o Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Hay Fever\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o Hives\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o o AIDS / HIV Positive\_\_\_\_\_\_\_\_\_\_\_\_

C. **Medical History** List medical illnesses, chronic conditions, hospitalizations and surgeries you have had.

Diagnosis Treatment Doctor Date of Diagnosis

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D. **Surgical History** List any surgeries that you have had. Have you been told to take antibiotics before surgery or dental work?

 o Yes o No

Diagnosis Treatment Doctor Date of Diagnosis

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E. **Current Medications** List all prescribed medications as well as all “over-the-counter” medications, vitamins, herbals and supplements.

Name of Drug Reason Taken Dose / Duration Date Started

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F. **Medication Reactions / Allergies** List each reaction which has occurred. Latex Allergy? o Yes o No

Medication / Substance Reaction Date of Occurrences

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G. **Family** Please mark all boxes and add details in blanks regarding health status or cause of death in immediate family.

o Heart Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Bleeding Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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o Anesthetic Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Deafness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Allergy / Hay Fever\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Asthma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Thyroid Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Kidney Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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o Hereditary Diseases\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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H. **Social** List all that apply. Chemical / Mold Exposure? o Yes o No

Type Duration When Stopped

1) Tobacco Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Alcohol Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) Street Drug Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) Current Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nursing Review By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_

Reviewing Provider’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_