

Comprehensive Patient History Form

Patient Name: _____ Today's Date _____
Age: _____ Date of Birth: ___/___/___ Male or Female _____

Reason for today's visit: _____
How long have you had this problem: _____
How severe is it? _____
What caused this problem? _____

Do you smoke? _____ Did you ever smoke? _____
Do you drink alcohol? _____ if so how much? _____
Allergies to any medications? _____

Please circle one or more as they apply to the following: Have you been diagnosed with any of the following?

Cancer	Arthritis	Diabetes	Stroke	Convulsions	High blood pressure
Heart attack	Anemia	GERD	Kidney Stones		Thyroid Disease
Other _____					

Family History

Mother's medical history _____
Father's medical history _____
Grandparents mother's side _____
Grandparents father's side _____
Siblings _____
Children _____

Please List any surgeries you have had.

Please List any Medications you are currently taking.

Patient or Patients guardian signature _____

The above information is accurate to the best of my knowledge. I also understand failure to provide correct information on this form or any other may result in the patient being dismissed from the practice.