All Clinics
Patient H&P Form
DATE:_____

PATIENT NAME:_____

DATE OF BIRTH:_____

MARITAL STATUS: SINGLE☐ MARRIED☐ DIVORCED☐ WIDOWED☐ STUDENT☐ CHILD☐

OCCUPATION:_____

REASON FOR VISIT:_____☐_____

PRESENT SYMPTOMS:_____

PLEASE LIST THE NAME AND CITY OF YOUR PRIMARY PHARMACY:

NAME:_____ CITY:_____

ARE YOU TAKING ANY MEDICATIONS NOW? (THIS INCLUDES PRESCRIPTIONS, OVER THE COUNTER, AND HERBAL MEDICATIONS): YES☐ NO☐

NAME OF MEDICATION	DOSAGE	HOW OFTEN

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES☐ NO☐

NAME OF MEDICATION	TYPE OF REACTION

SOCIAL HISTORY

Do you use any tobacco products of any kind? YES☐ NO☐

Approximately how much? _____ How many years? _____ How long did you quit? _____

Do you consume alcohol? YES NO

Approximately how much? _____ How many years? _____ How long did you quit? _____

Reference: ISO 9001: 2015, Formulation date: 8/16, Revision: 9/16, Approved by: T.Gipson, RN, Clinic nurse manager

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MEDICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH THE FOLLOWING PROBLEMS? (CIRCLE ALL THAT APPLY)

CANCER: YES ☐ NO ☐ **IF YES, WHAT KIND?** _____

LIVER:	YES ☐	NO ☐	**EMPHYSEMA:**	YES ☐	NO ☐
ASTHMA:	YES ☐	NO ☐	**HIV:**	YES ☐	NO ☐
KIDNEY DISEASE:	YES ☐	NO ☐	**SEIZURES:**	YES ☐	NO ☐
ANEMIA:	YES ☐	NO ☐	**REFLUX:**	YES ☐	NO ☐
STROKE:	YES ☐	NO ☐	**ULCERATIVE COLITIS:**	YES ☐	NO ☐
COPD:	YES ☐	NO ☐	**HEART ATTACK:**	YES ☐	NO ☐
SLEEP APNEA:	YES ☐	NO ☐	**ANXIETY:**	YES ☐	NO ☐
HIGH CHOLESTEROL:	YES ☐	NO ☐	**DIABETES:**	YES ☐	NO ☐
HIGH BLOOD PRESSURE:	YES ☐	NO ☐	**HYPERTHYROIDISM:**	YES ☐	NO ☐
HEART DISEASE:	YES ☐	NO ☐	**CONGESTIVE HEART FAILURE:**	YES ☐	NO ☐

OTHER CONDITIONS NOT LISTED: _____

PLEASE LIST ALL SURGERIES AND INCLUDE DATES (APPROXIMATE):

PROCEDURE/SURGERY	**DATE**
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

DOES ANY MEMBER OF YOUR FAMILY HAVE PROBLEMS WITH ANY OF THE FOLLOWING? IF SO, PLEASE LIST RELATIONSHIP TO PATIENT

	MOTHER		**FATHER**	
HEART DISEASE	YES ☐	NO ☐	YES ☐	NO ☐
HIGH BLOOD PRESSURE	YES ☐	NO ☐	YES ☐	NO ☐
ASTHMA	YES ☐	NO ☐	YES ☐	NO ☐
STROKE	YES ☐	NO ☐	YES ☐	NO ☐
DIABETES	YES ☐	NO ☐	YES ☐	NO ☐
CANCER	YES ☐	NO ☐ **TYPE**_____	YES ☐	NO ☐ **TYPE**_____
DECEASED	YES ☐	NO ☐	YES ☐	NO ☐
CAUSE OF DEATH: _____			**CAUSE OF DEATH:** _____	

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REVIEW OF SYSTEMS

(PLEASE CIRCLE ALL THE FOLLOWING SYMPTOMS YOU RECENTLY HAD)

GENERAL HEALTH:
FEVER ☐ **CHILLS** ☐ **UNINTENTIONAL WEIGHT LOSS** ☐ **SLEEPING PROBLEMS** ☐

FATIGUE ☐ **DIZZINESS** ☐ **WEIGHT GAIN** ☐

LUNG AND RESPIRATORY:
FREQUENT NONPRODUCTIVE COUGH ☐ **FREQUENT PRODUCTIVE COUGH** ☐ **SHORTNESS OF BREATH** ☐

WHEEZING ☐

HEART AND CIRCULATION:
BLACKING OUT OR FAINTING ☐ **CHEST PAINS** ☐ **IRREGULAR HEARTBEAT** ☐ **SWELLING OF ANKLES** ☐

CHEST DISCOMFORT ☐ **TROUBLE BREATHING ON EXERTION** ☐ **CALF OR LEG PAIN** ☐

GASTROINTESTIONAL:
ABDOMINAL PAIN ☐ **DIARRHEA** ☐ **BLOATING** ☐ **CONSTIPATION** ☐ **HEARTBURN** ☐

NAUSEA ☐ **VOMITING** ☐ **LOSS OF APPETITE** ☐

GENITOURINARY:
BLOOD IN URINE ☐ **PAINFUL URINATION** ☐

SKIN/NAILS:
ABSCESS ☐ **CYST** ☐ **INGROWN TOENAIL** ☐ **KELOID** ☐ **LESION** ☐ **MOLE** ☐

SKIN TAG ☐ **TUMOR/MASS** ☐ **ULCER** ☐ **WART** ☐ **BREAST MASS/PAIN** ☐

ENDOCRINE:
EXCESSIVE HUNGER ☐ **EXCESSIVE THIRST** ☐ **EXCESSIVE SWEATING** ☐

INCREASED/ DECREASED ENERGY LEVEL ☐ **UNWANTED WEIGHT CHANGE** ☐

PLEASE LIST ANY OTHER SYMPTOMS YOU CURRENTLY HAVE THAT ARE NOT LISTED ABOVE:

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Revision History

Author	Revision Date	Page #	Summary of Changes
Tawana Gipson	8/26/16	all	Header and footer added
Tawana Gipson	9/13/16	All	Combined to 3 pages from 4
Tawana Gipson	8/16	Pg. 3	Spelling errors corrected

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