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 EVERY SEEN A HEART DOCTOR OR CARDIOLOGIST? Yes No

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
________________________________	___________________________________
________________________________	___________________________________
________________________________	___________________________________
________________________________	___________________________________

DO YOU HAVE A PACEMAKER OR DEFIBULATOR OR OTHER CARDIAC DEVICE? YES NO

HAVE YOU EVER HAD A HEART CATH OR HEART PROCEDURE/SURGERY? YES NO

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: ___________________________

Reference: ISO 9001: 2015, Formulation date: 8/16, Revision: 8/16, 9/16,11/16 Approved by: T.Gipson, RN, Clinic nurse manager

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PATIENT NAME: ____

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:

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	11/8/16	Pg. 3	Spelling errors corrected

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