OCH REGIONAL MEDICAL CENTER

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 ago did you quit? _____

Do you consume alcohol? YES NO

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

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Patient H&P Form
NAME: _____

MEDICAL HISTORY

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

CANCER: YES NO; IF YES, WHAT KIND? _____ DATES:_____

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 COLITUS:	YES	NO
COPD:	YES	NO	HEART ATTACK:	YES	NO
HIGH CHOLESTERAL:	YES	NO	ANXIETY:	YES	NO
HIGH BLOOD PRESSURE:	YES	NO	DIABETES:	YES	NO
HEART DISEASE:	YES	NO	HYPERTHYROIDISM:	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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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:

NOTE: This is the final page of the OCH Policy/Form. Next page contains revision history only.