

GANT PATIENT HISTORY FORM (TO BE COMPLETED BEFORE VISIT/CONSULTATION)

Name: _____
First Middle Last

DATE: _____ Birth Date: _____

SS #: _____ VERSION OCT 2008

Your age: _____

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

Doctor requesting Consultation: _____ PCP if different from this Dr: _____

Habits, Social History (Answer, or circle if item is applicable to your history)

Occupation _____ Marital: Married Divorced Widow Single Children (#): _____
 Do you smoke? Yes No _____ Do you use other forms of tobacco? Yes No _____
 Do you drink alcohol? Yes No Amount per day/week _____
 If sexually active with more than one partner, do you use "safe sex practices?" Yes No Not Applicable
 Have you ever used IV Drugs? Yes No If "Yes", have you had tests for: AIDS Hepatitis B Hepatitis C
 Circle the immunizations or vaccinations you have had: Hepatitis B <> Hepatitis A <> Influenza <> Pneumonia

Past History – Surgical (Circle if you have had any of the following)

Appendix removed	Ulcer Surgery	Heart Surgery Bypass	Other Surgery _____
Gallbladder Removed	Colon Surgery	Heart Valve Surgery	Anesthesia problems
Hiatal Hernia Surgery	Hemorrhoid Surgery	Pacemaker	Blood Transfusions (dates _____)
Groin Hernia Surgery	Prostate Surgery	Automatic Defibrillator	Blood Donation (dates _____)
Other Hernia Surgery	Joint Replacement	Uterus Removal (hysterectomy)(ovaries removed or ovary(ies) remain)	

Past History - NonSurgical (Circle if you have or have had the following)

Hiatal Hernia	Crohn's Disease	Anemia	Asthma
Reflux (GERD)	Ulcerative Colitis	Heart disease (angina, heart attack)	Bleeding Problems
Ulcers (Peptic)	Diverticulosis	High Blood Pressure	Diabetes
Gallstones	Colon Polyps	Stroke/ T.I.A.	Thyroid Problems
Other Liver Problems	Irritable Bowel	Kidney disease/stones	Rheumatic Fever
Hepatitis (any type)	Cancer (type _____)	Emphysema	Seizure disorder
Cholesterol problems	Prostate problems	Sleep apnea	Other _____

Family Medical History (Has ANYONE in your immediate family (Mother/Father/Bro-Sis) has had any of the following):

Cancer of Colon/Rectum/Small intestine /Stomach /Pancreas /Liver /Breast /Uterus /Ovary/Kidney/ Other: _____
 Colon Polyps Gallstones Pancreatitis Peptic Ulcer
 Crohns Disease Ulcerative Colitis Liver disease Heart disease

Family History (circle applicable or briefly answer)

Your Mother: Living / Deceased Current health or cause of death/age: _____
 Your Father: Living / Deceased Current health or cause of death/age: _____
 Sisters # _____ # Living _____ # Deceased _____ Health/cause of death/age: _____
 Brothers # _____ # Living _____ # Deceased _____ Health/cause of death/age: _____

List all prescription and non-prescription medicines you take on a regular or frequent basis)

(The nurse will go over with you the doses and the schedule you take these on)

- | | | |
|----|----|----|
| 1. | 4. | 7. |
| 2. | 5. | 8. |
| 3. | 6. | 9. |

MEDICINE ALLERGIES? List ↓

Do you use "Non Steroidal Anti-inflammatory Drugs" (Aspirin, Advil, Ibuprofen, and Aleve) regularly? Yes / No
 Do you use any Herbal Products/Health Food Store Products? Yes / No If yes, please list:

SYSTEM REVIEW (fill in the blank, or circle symptoms/conditions you have)

GENERAL:	Weight gain Feeling tired	Weight loss Fever/Chills
HEART:	Chest pain/angina Slow or fast heart rate	Palpitations Leg pain with exertion
LUNGS/PULMONARY:	Cough Shortness of breath with exertion Shortness of breath lying down or sleeping	Shortness of breath Wheezing/asthma
GENITOURINARY:	Pain with urination Last period: _____ Vaginal discharge	Incontinence Pelvic pain or pain during menses Abnormal vaginal bleeding
WOMEN:	Hesitancy Frequent nighttime urination	Genital lesions Testicle pain
MEN:		
MUSCULOSKELETAL:	Joint pain Joint stiffness	Joint swelling Arm/leg swelling
HEME:	Abnormal Bleeding Swollen glands	Abnormal Bruising Anemia in past
ENDOCRINE:	Muscle weakness Voice deepening	Hot flashes Eye bulging General weakness

EYES:	Eye pain Eye drainage	Dry eyes Itchy eyes	Red eyes Eyesight problems
ENT:	Earache Sore throat	Bloody nose Hearing loss	Nasal discharge Hoarseness
GI:	Loss of appetite Difficulty Swallowing Frequent nausea Change in bowel habits Constipation	Heartburn Frequent Vomiting Pain in Abdomen Diarrhea Blood in stools	Indigestion
SKIN:	Skin lesions Breast pain	Itching Breast mass	Skin wound Change in a mole
NEURO:	Convulsions Confusion Difficulty walking	Headache Dizziness Limb weakness	Fainting
PSYCH:	Anxiety Suicidal thoughts Personality change	Depression Sleep disturbance Emotional problems	Bipolar disease

Patient signature

Patient Name (please print)

↓ **PLEASE DO NOT WRITE BELOW THIS LINE** ↓

PHYSICAL EXAMINATION: (to be completed by office personnel)

Vital Signs: **Wt:** _____ **BP:** _____ **Pulse:** _____ **Temp:** _____ **Appearance:** _____

Skin: insp/palpate: **Lymphatic:** Neck/axillae/groin/other **HEENT:** Eyes-conj/pupils Ears / Oropharynx

Neck: Supple/thyroid **Chest:** Effort/perc/auscul: **Heart:** Ausc/carotids/AAA/Fem art/edema:

Abdomen: Mass/L-S/Hernia/Ascites: **Rectal:** Tone/mass/hemorr/guaiaac/prostate: **Neurological:** Cranial nerves, DTR, Gait

Musculoskeletal: Edema, Swelling, ROM **Psychiatric:** Judgment, affect, orientation,

Lab tests w/ Dates: **X-ray Review:** facility dates: **Old Records Review Source:**

Assessment(s):

- 1.
- 2.
- 3.
- 4.

Plan:

1. **Diagnostic:**
2. **Therapeutic:**
3. **Educational:**
4. **Other:**

Doctor's Signature / Date:

Dictated / Date: Other: