



## Patient History Form

**Please complete the form prior to your appointment. Once completed either send to us via the Spruce App or bring to your first appointment.**

Full Name:

Date of Birth:

Date:

### **Tell us about yourself:**

#### **Home situation** (circle, or add in writing):

Single \_\_\_\_\_ Married (how long \_\_\_\_\_) Divorced (how long \_\_\_\_\_) Widowed (how long \_\_\_\_\_)

Domestic partnership \_\_\_\_\_ Children \_\_\_\_\_ Are they healthy? \_\_\_\_\_

#### **Employment:**

Status: full-time \_\_\_\_\_ part-time \_\_\_\_\_ retired \_\_\_\_\_ disabled \_\_\_\_\_ homemaker \_\_\_\_\_

#### **Occupation:**

type of work/jobs: \_\_\_\_\_

#### **Habits:**

Do you smoke? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, how many packs per day? \_\_\_\_\_  
If you have quit, how long ago? \_\_\_\_\_

Do you use other tobacco products? No \_\_\_\_\_ Yes \_\_\_\_\_ If so, which products? \_\_\_\_\_

Do you use alcohol? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, how often do you drink? \_\_\_\_\_  
If you have quit, how long ago? \_\_\_\_\_  
Do family or friends worry about your alcohol intake? \_\_\_\_\_

Do you use illicit drugs? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please specify \_\_\_\_\_

#### **Nutrition Habits:**

1. How would you describe your eating habits?

2. Would you like to increase or decrease your weight?
3. Are you on a special diet (diabetic, low fat, vegetarian, etc.?)

**Exercise Habits:**

1. Do you exercise on a regular basis? (3 or more times/week for 20-30 minutes or more)
2. What type of exercise do you do?
3. If you do not exercise is it due to a particular reason (physical limitations, job, family life, etc.?)

**Psycho/Social:**

1. Do you feel like your life has a purpose?
2. How would you describe your overall mood?
3. Are you or have you undergone any major issues/stresses in your life?
4. If yes, how do you cope with these issues or stressors?

**Allergies or Adverse Drug Reactions:**

Please list drug and type of reaction

**Past Medical History:**

Please list other diseases from which you currently suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the past:

**Surgical History:**

Please list any surgeries (operations), reason for the surgery, and the date of the surgery:

**Medications:**

Prescription medications	Dose	How often taken

**Non-prescription /Supplements** (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

**Family History:**

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

**Do you have Health Care Surrogate/Health Care Directives?** (If yes, please provide a copy at your first visit)

**Immunizations:** if YES, give approximate year given

Pneumococcal            No \_\_\_\_\_ Yes \_\_\_\_\_  
 Hepatitis A                No \_\_\_\_\_ Yes \_\_\_\_\_  
 Hepatitis B                No \_\_\_\_\_ Yes \_\_\_\_\_  
 Tetanus                    No \_\_\_\_\_ Yes \_\_\_\_\_  
 Shingles                    No \_\_\_\_\_ Yes \_\_\_\_\_  
 HPV Vaccine                No \_\_\_\_\_ Yes \_\_\_\_\_

**Safety:**

Do you use seatbelts?    No \_\_\_\_\_ Yes \_\_\_\_\_

**Transfusions:**

Have you ever received a blood transfusion? No \_\_\_\_\_ Yes \_\_\_\_\_ When? \_\_\_\_\_

Please mark any symptoms you are currently experiencing or have experienced in the last month:

**SYMPTOM REVIEW**

**Gastrointestinal**

- poor appetite
- abdominal pain
- indigestion
- trouble swallowing
- diarrhea
- constipation
- change in bowel habits
- nausea or vomiting
- rectal bleeding or blood in stools
- history of liver disease or abnormal liver tests

**Cardiovascular**

- chest pain
- history of angina or heart attack
- history of high blood pressure
- history of irregular beat
- history of poor circulation

**Pulmonary/lungs**

- shortness of breath
- persistent cough
- coughing up blood
- asthma or wheezing

**Muscle/joint/bone**

- swelling of ankles or legs  
pain, weakness or numbness in
- arms or hands
- back or hips
- legs or feet
- neck or shoulders

**Neurologic**

- history of stroke
- blackouts or loss of consciousness

**General**

- weight gain/loss of 10+ lbs during last 6 months
- poor sleep
- fever
- headache
- depression

**Eyes, ears, nose, throat**

- blurred vision
- other change in vision
- history of glaucoma or cataracts
- loss of hearing
- ringing in ears
- sinus problems
- hoarseness

**Genitourinary**

- frequent or painful urination
- blood in urine

**Skin**

- itching
- easy bruising
- change in moles

**Endocrine**

- history of diabetes
- history of thyroid disease
- change in tolerance to hot or cold weather
- excessive thirst

**Women only**

- abnormal Pap smear
- bleeding between periods
- date of last mammogram \_\_\_\_\_

**Men only**

- PSA

**Anything else?**

Are you experiencing an unusually stressful situation?

Are there any specific personal issues you would like to bring up at the time of your visit?

**PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT**