St.JosephHealth
Mission Heritage Medical Group
A member of the St.Joseph Hoag Health alliance

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INITIAL PATIENT HISTORY

Name:_____ HT:_____ DOB: _____ Age: _____ Today's date: _____

Referred by:_____ Primary Care Physician: _____

☐ I do not have a primary physician

History of Present Illness

What is the main reason for your visit today? _____

_____

Severity of the problem(s) (Check one or more)

☐ Mild ☐ Moderate ☐ Severe

☐ Stable ☐ Worsening ☐ Improving

How long have you experienced this problem(s)?

Days_____ Weeks_____

Months_____ Other_____

Are there any other associated signs or symptoms? ☐ Yes ☐ No

If yes, please explain: _____

Does anything help or make the problem worse? ☐ Yes ☐ No

If yes, please describe: _____

Is the problem constant or variable?

☐ *Comes and goes* ☐ *Always there* ☐ *Other*_____

Past Medical History: *(Check if you have ever had or been diagnosed with any of the following. Please add details in blank spaces if needed)*

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bleeding Problems
- ☐ Bowel Troubles
- ☐ Cancer
- ☐ Chronic Lung Disease
- ☐ Colonoscopy
- ☐ Deep Venous Thrombosis/Pulmonary Embolism
- ☐ Depression
- ☐ Diabetes
- ☐ Other_____
- ☐ Epilepsy / Seizures
- ☐ Eye Problems
- ☐ Fibrocystic Breast Disease
- ☐ Gallbladder Problems
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Infection
- ☐ Other_____
- ☐ Kidney Stones
- ☐ Mental Illness
- ☐ Migraines
- ☐ MRSA (staph infection)
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Transfusions
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Uterine Fibroids
- ☐ Other_____

Past Surgical History: *(Check and date any that you have had)*

- ☐ Appendectomy _____
- ☐ Breast _____
- ☐ Back _____
- ☐ Other _____
- ☐ Cesarean Section _____
- ☐ D&C_____
- ☐ Gallbladder _____
- ☐ Heart _____
- ☐ Hysterectomy _____
- ☐ Ovary_____
- ☐ LEEP or Cryo _____
- ☐ Tonsillectomy_____
- ☐ Tubal Ligation _____
- ☐ Cosmetic _____

Gynecologic History: *(Fill in the blanks or check boxes where appropriate)*

Age at first menstrual period: _____ Years

Frequency of periods, every _____ days

Length of each period: _____ days

Flow (check): ☐ Light ☐ Medium ☐ Heavy

If heavy, number of tampons or pads used per day:_____

Breakthrough bleedings? Y / N Clots? Y / N

Last Normal Period: _____ / _____ / _____

Age at Menopause: _____

Date of last mammogram: _____

Last Pap Smear: _____ / _____ / _____

Result of last pap:_____

Any abnormal Pap? Y / N Type: _____

What do you do to prevent pregnancy?_____ Check if you have any: ☐ Endometriosis ☐ Fibroids ☐ Ovarian Cysts

Any STD (Sexually transmitted disease)? ☐ Gonorrhea ☐ Chlamydia ☐ Herpes (Genital) ☐ HPV ☐ Syphilis ☐ Trichomonas ☐ Other_____

Obstetric History: *(Fill in the blanks)*

Total # of pregnancies:_____ Full Term:_____ Preterm:_____ Abortions:_____ Miscarriages:_____ Tubal Pregnancies:_____ Living Children:_____

Date	Weeks Gestation	Hours in Labor	Birth Weight	Baby's Sex	Type of Delivery	Anesthesia	Early Labor?	Complications	Location

Current Medications: *(List and provide information regarding all medications including over the counter, vitamins, herbal remedies, etc. You may use additional pages if necessary. Please bring all your medications with you to your appointment.)*

Medication	Strength	How Often	Prescribed By	Reason

Allergies: *(List known allergies and reactions to medications or substances (e.g. latex, iodine)* ☐ **No Known Allergies**

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Family History: *(Please check if any of your family members have had the following, include age at diagnosis if possible.)*

	Mother	Father	Brother	Sister	Mom's Mother	Dad's Mother	Mom's Father	Dad's Father	Aunt	Uncle
Breast Cancer										
Colon Cancer										
Diabetes										
Heart Disease / MI										
High Blood Pressure										
Ovarian Cancer										
Uterine Cancer										
Stroke										
Other Cancer										
Other Medical Problem or Genetic Disorder										

Social History: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed **Education:** ☐ Grade School ☐ High School ☐ College ☐ Postgraduate

Are you living with your husband or partner? ☐ Y ☐ N

Is your sex life satisfactory? ☐ Y ☐ N

Do you have dependents at home? ☐ Y ☐ N

Are you employed? (Describe) ☐ Y ☐ N _____

Are you exposed to fumes or solvents? ☐ Y ☐ N _____

Do you exercise regularly; how many times per week? ☐ Y ☐ N _____

Do you drink alcohol; how much per week? ☐ Y ☐ N _____

Do you smoke; how many years, and how much daily? ☐ Y ☐ N _____

Do you or have you used any recreational or IV drugs? ☐ Y ☐ N _____

Have you been sexually, physically, emotionally abused, threatened, or hurt by anyone? ☐ Y ☐ N _____

Review of Systems (Current Illness)

Constitutional	Circle One	
Weight Loss	Yes	No
Weight Gain	Yes	No
Fatigue	Yes	No
Fever	Yes	No
Eyes		
Glasses or contacts	Yes	No
Vision Changes	Yes	No
ENT/Mouth		
Sinus problems	Yes	No
Hearing problems	Yes	No
Cardiovascular		
Chest pain	Yes	No
Difficult breathing on exertion	Yes	No
Swelling of legs	Yes	No
Palpitations of heart / skip beats	Yes	No
Varicose veins	Yes	No
Respiratory		
Wheezing	Yes	No
Shortness of breath	Yes	No
Coughing up blood	Yes	No
Allergic / Immunologic		
Allergies / Hay fever	Yes	No

Gastrointestinal	Circle One	
Frequent Diarrhea	Yes	No
Blood in stool	Yes	No
Abdominal pain	Yes	No
Nausea / Vomiting	Yes	No
Constipation	Yes	No
Genitourinary		
Blood in urine	Yes	No
Pain with urination	Yes	No
Urgency to urinate	Yes	No
Frequency of urination	Yes	No
Incomplete emptying	Yes	No
Urine loss when straining	Yes	No
Unintended urine loss	Yes	No
Abnormal discharge / odor	Yes	No
Abnormal periods / bleeding	Yes	No
Painful periods	Yes	No
Painful intercourse	Yes	No
Skin / Breast		
Rash	Yes	No
Ulcers	Yes	No
Pain in breast	Yes	No
Nipple discharge	Yes	No
Lumps / Masses in Breast	Yes	No

Neurological	Circle One	
Dizziness / Loss of Consciousness	Yes	No
Seizures	Yes	No
Numbness / Tingling	Yes	No
Trouble Walking	Yes	No
Headache	Yes	No
Psychiatric		
Are you generally satisfied about life?	Yes	No
Depression	Yes	No
Any thoughts of harming yourself or others?	Yes	No
Endocrine		
Hot flashes / Night sweats	Yes	No
Too hot / cold intolerance	Yes	No
Hematologic / Lymphatic		
Frequent bruises / Bleeding easily	Yes	No
Blood clotting problems in veins	Yes	No
Musculoskeletal		
Muscle weakness	Yes	No

Other problems not listed

_____

Patient Signature Doctor Signature Date