Patient Visit History Form *(v.Jan 5 2016)*

PATIENT NAME: _____ Age _____

DEAR PATIENT,

Please **CIRCLE** items that apply to you. You may enter dates as well (month/year) and write on the form as needed. This will assist us in entering the information to the electronic chart.

Chief Complaints: (please check applied boxes and fill out):

- ☐ New patient to practice
- ☐ Routine Physical Blood Pressure Heart Rate Labs Exam
- ☐ Symptoms of: pain/pressure/tightness/heaviness in chest or arm
- ☐ Symptoms of: palpitations, elevated blood pressure, shortness of breath, numbness
- ☐ Family History or Other symptoms: _____.
- ☐ Had recent healthcare visit with Doctors: _____.
- ☐ Had recent hospital or urgent care visit at: _____.
- ☐ Had recent procedure/tests/surgery for: _____.
- ☐ Request additional opinion for diagnosis of: _____.
- ☐ 8. My main reason to be here is: _____.

History of Present Illness (HPI): (please circle or fill in):

Demographics :

Background History How young are you? _____ Gender _____
Marital Status: single/married/divorced/separated/widowed/domestic partner
Referred by: phone book/internet/patient/Insurance panel/Hospital/Urgent care/Doctor
How many children do you have? _____
Any children in town? Yes / No Any other family in town? _____
Where did you move from? _____
When did you move to Nevada? _____(month/year)
Smoking Status: nonsmoker, prior smoker, active smoker, rare use of nicotine
Alcohol Intake: none, minimal, social drinker, frequently or daily
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DOCTORS & other Healthcare PROVIDERS:

Provider Names Who is your Primary Doctor? _____

Is there a Doctor who referred you to us? _____

Consultants Names:

Orthopedic:
Endocrinologist:
Pain Management:
Gynecology:
Urology:
Dermatology:
Eye/Ear/ENT:
Gastroenterologist:
Hematology/Oncologist:
Other Doctors:

Interim History (please circle any tests you have had done):

Tests/Studies performed was:

EKG, HOLTER, Echocardiogram, Stress or Nuclear test, Pacemaker, Heart Tests
Angiogram:
Carotid Ultrasound, Leg Ultrasound
Mammogram, DEXA Scan,
CAT Scan:
Ultrasound: Abdomen, Pelvic, Kidney, Liver
MRI Scan:
PET Scan:
Sleep study, Pulmonary function tests, Allegy Testing
Injection Epidural or Nerve Ablation
Nerve Study, EEG, MRI Scan
Colonoscopy, Endoscopy, Cystoscopy,
Radiation Therapy , Chemotherapy or Biopsy

- Post procedure: Bring in any recent Operative Procedure reports
- Rx management: Bring in any Rx medications or OTC bottles to review
- Lab Result: Bring in any Lab test results

DISCUSSION: Is there any specific question you have for the Doctor?

_____

_____

Medications: (please list them)

DRUG NAME	Dose Amount	Frequency	Prescribing Doctor

Medical History: ***PLEASE CIRCLE ANY THAT YOU HAD WITH DATE (month/year):***

- Heart Attack, Sudden Death, Heart Failure
- CAD Coronary Artery Disease, Angina, Angioplasty Stent in Heart
- Hypertension, Kidney Disease, Dialysis, Aneurysm, Enlarged Heart, LVH
- Valvular Heart Disease Mitral Valve, Aortic Valve, Hole in the Heart
- Atrial Fibrillation or Flutter, PVC, Arrhythmia, Pacemaker Defibrillator
- Pulmonary, Shortness of Breath, COPD, Emphysema, Asthma
- PAD Peripheral Arterial Disease, Leg pain Claudication, Aneurysm Stent, Bypass
- Carotid Artery Disease, TIA (mini Stroke), STROKE, Syncope Fainting
- Brain Tumor, Neuropathy, Abnormal Brain Scan, Migraines, Vision loss
- Orthopedic: Arthritis degenerative, rheumatoid, fibromyalgia, nerve damage, Joints
- Gastro GI: Acid Reflux, Hiatal Hernia, Gallbladder, Appendix, Peptic Ulcer, H. Pylori
- GU: Urinary symptoms, kidney stones, bladder leakage/spasm, prostate, kidney cyst
- SKIN: psoriasis, dermatitis, cellulitis, lesions/moles, pre cancer, acne, tattoos
- Diabetes, Thyroid, High Cholesterol or Lipids, Parathyroid, Adrenal, Testosterone
-
- OTHER: _____
-
- OTHER: _____

Allergy:

Are you allergic to Iodine, Penicillan, Sulfar, Radiocontrast Contrast?

Any drug allergy:

OB-GYN History:

Last pap smear date: _____ Last mammogram date:_____

Total pregnancies number: _____. Total living children number: _____.

Surgical History: ***PLEASE CIRCLE ANY THAT YOU HAD WITH DATE (month/year):***

- Pregnancy C Section, Hysterectomy TAH, Ovary, Breast Biopsy
- Appendix, Tonsils, Skin Biopsy or Cancer
- Colonoscopy (?any polyps) , Endoscopy, Gallbladder, Liver, Pancreas
- Prostate , Bladder Cystoscopy or Renal Kidney
- Arthroscopy , Joint replacement , Spine
- Angiogram Heart Carotid Leg , Angioplasty Stenting , Bypass Vascular Heart or Shunt
- Venous Stripping or Ablation
-
- OTHER: _____
-
- _____

Hospitalization/Major Diagnostic Procedure/Urgent Care Visit:

_____

Family History:
CIRCLE Family Status; ENTER Birthyear; CIRCLE if any family medical condition applies:

Daughter: n/a, alive deceased, unknown
Birth year:_____has h/o diabetes/hypertension/heart disease/stroke/cancer
Father: n/a, alive deceased, unknown
Birth year:_____has h/o diabetes/hypertension/heart disease/stroke/cancer
Son: n/a, alive deceased, unknown
Birth year:_____has h/o diabetes/hypertension/heart disease/stroke/cancer
Spouse: n/a, alive deceased, unknown
Birth year:_____has h/o diabetes/hypertension/heart disease/stroke/cancer
Mother: n/a, alive deceased, unknown
Birth year:_____has h/o diabetes/hypertension/heart disease/stroke/cancer

Siblings: _____ # of brothers _____ # of sisters _____ check if healthy
Children: _____ # of sons _____ # of daughters _____ check if healthy
Social History: circle one of the following:
Never smoked / former smoker / smoking actively / nicotine usage

REVIEW OF SYSTEMS (ROS):
PLEASE CIRCLE ANY MAJOR SYMPTOMS YOU HAD IN THE PAST MONTH:
Cardiovascular:
Cyanosis - Difficulty lying flat – Dizziness - Dyspnea on exertion - Fluid accumulation in the legs - Irregular heartbeat -Shortness of breath – Chest Pain – Fainting -
General/Constitutional:
Change in appetite denies. Chills denies. Fever denies. Headache denies.
Allergy/Immunology:
Blistering of skin – Hives – Rash – Sneezing
Ophthalmologic:
Blurred vision - Discharge - Floaters in the visual field – Pain in eyes
ENT:
Blocked ear - Decreased sense of smell - Ear pain - Nosebleed - Swollen glands
Endocrine:
Cold intolerance - Excessive sweating - Heat intolerance - Flushing
Respiratory:
Breathing pattern – Hemoptysis - Pain with inspiration
Gastrointestinal:
Blood in stool - Decreased appetite - Difficulty swallowing – Heartburn
Hematology:
Fever - Groin mass - Prolonged bleeding – Bruising - Swollen glands
Genitourinary:
Abdominal pain/swelling - Blood in urine - Painful urination
Skin:
Acne - Blistering of skin - Hives - Keloid formation - Nodule(s) - Skin oozing
Neurologic:
Tics – Seizures – Recent Stroke – Tremors
Podiatric:
Achilles pain - Achilles swelling - Ball of foot pain - Fever - Foot pain - Joint dislocation - Redness over the Achilles - Wound oozing
Psychiatric: Auditory/visual hallucinations - Delusions - Eating disorder - Substance abuse