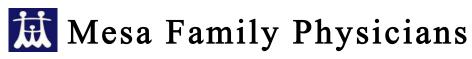


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PATIENT HISTORY QUESTIONNAIRE

Name:		DOB:	Date:_		
Preferred Communication: Cell phone #			_ (or) Home #		
Gender:	Preferred Language	e: English / Spanish / Othe	r Marital Statu	s:	
Race: Caucasian / A	sian / Latino / African	American / Other			
Pharmacy Name &	Number:				
Medications:	YES (list meds/over the counter supplements below) No (I do not take medications or over the counter supplements)				
	·	ncluding over the counter			
Name of	Medicine	Dosage & How often t	aken Reasor	n for taking this med	
Allergies:	Yes (list below)	No Allergies			
List all Allerg	ies - such as food, me	dications, chemicals, etc.			
Allergy			Reacti	on	
Doctors: Please list	all doctors currently in	nvolved in your care.			
		Phone #		Reason	



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Name:		DOB:	Date:		
Family History: Please chec	k box for past or	present conditions.			
Medical Problems	Mother	Father	Siblings	Grandparents	
High Blood Pressure				_	
Lung Disease					
Bleeding Problems					
Diabetes					
Stroke					
Heart Disease					
Cancer					
Other					
Past Medical History – Diag	nosed: Check all	that apply	dical history of the above of		
☐ High Blood Pressure ☐ Atrial Fibrillation		Bleeding Disorder COPD/Chronic Bronchitis	☐ Hepatitis ☐ Anemia	B Or C	
☐ Asthma		Diabetes	☐ Anemia☐ Infection	c	
☐ Sleep Apnea		Stroke	☐ Bowel Di		
☐ Acid Reflux		Kidney Problems	☐ Rheumat		
☐ Heart Disease		•	☐ Seizures		
☐ High Cholesterol		HIV	☐ Thyroid (Disease	
☐ Gout					
☐ Cancer (please write in):		tal Illness: Depression Bipolar Anxiety Other	☐ Other mo		
Past Surgical, Hospitalizatio dates they were performed.		-	ries, hospitalizations {	& injuries and the	
☐ Hysterectomy		Tonsils/Adenoids	☐ Gall Blad		
Ovaries removed? yes /		Muscle/Joint surgeries	☐ Colonoso	сору	
☐ Appendix ☐ Any Biopsies? (please list ————————————————————————————————————		Cataracts Other (explain)			
Personal Social History: Tobacco Use: (never) Alcohol Use: (never) (rar	 (quit/when: _ ely) (moderate)		urrent smoker/ pac		
, , ,					
Occupation:					

Mesa Family Physicians

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Name:		DOB:_		Date:		
Review of System	is: (Please cir	cle yes or no)				
General/Constitutional:		Genitourinary:		Women's Health:		
Weight Gain?	Yes / No	Kidney stones?	Yes / No	Number of pregnancie	es?	
Weight Loss?	Yes / No	Blood in urine?	Yes / No	Number of deliveries?		
Fever?	Yes / No	Testicle pain?	Yes / No	Age of 1 st pregnancy?		
Fatigue?	Yes / No	Menstrual problems?	Yes / No	How many years have	you used birth	
Change in Appetite?	Yes / No			Control or Hormone Replacement		
Night Sweats?	Yes / No	Neurologic:		Therapy?		
		Tingling/Numbness?	Yes / No	Did you breast feed?	Yes / No	
Ophthalmologic:		Convulsions/Seizures?	Yes / No	Menses started at what age?		
Blurred double vision?	Yes / No	Frequent headache?	Yes / No	What age did Menopause		
Glasses/contacts?	Yes / No	Paralysis/Tremor?	Yes / No	Begin?		
Glaucoma?	Yes / No	Loss of use of extremity	Yes / No	-0		
Eye/Disease/Injury?	Yes / No			Screening Dates:		
ENT:		Hematology:		When was your last:		
Ringing in ears?	Yes / No	Bruise easily?	Yes / No	Screening Mammogram		
Sore throat?		Slow to Heal?	Yes / No	Screening Pap Smear		
	Yes / No	Enlarged glands?	Yes / No	Screening Pelvic Exam		
Sinus problems?	Yes / No			Screening EKG		
Decreased hearing?	Yes / No	<u>Skin:</u>		Screening Colonoscopy		
Nosebleed?	Yes / No	Rash?	Yes / No	Last Eye Exam		
Cardiovascular:		Itching?	Yes / No	By whom?		
Chest pain at rest?	Yes / No	Change in hair/nails?	Yes / No	-		
Chest pain w/exertion?	Yes / No			Vaccinations:		
Palpitations?	Yes / No	Gastrointestinal:		Date of last	Pneumonia	
Heart trouble?	Yes / No	Nausea?	Yes / No	vaccine		
Fluid accumulation in	1657 116	Vomiting?	Yes / No	Date of	last Flu	
legs?	Yes / No	Abdominal pain?	Yes / No	vaccine	_	
10831	. 65 / . 16	Rectal bleeding?	Yes / No			
Respiratory:		Bowel problems?	Yes / No	Advanced Directives:		
Shortness of breath?	Yes / No	All //		Do you have Advanced	d Directives in	
Shortness of breath		Allergy/Immunology:	V / N-	place? Yes / No		
w/ exertion?	Yes / No	Food Allergy?	Yes / No	Does your doctor have	e a copy?	
Wheezing/Asthma?	Yes / No	Other?	Yes / No	Yes / No		
Coughing up blood?	Yes / No	(if yes, let provider know)				
Endocrine:		I have reviewed this packet & I Atte		acket & I Attest		
Excessive thirst?	Yes / No	Insomnia?	Yes / No	to its validity:		
Thyroid disease?	Yes / No	Confusion/Memory loss?	•	Please initial Date		
Hormone problem?	Yes / No	Depression?	Yes / No			
Musculoskeletal:						

Breast:

Nipple discharge?

Breast pain?

Breast lump?

Yes / No

Yes / No

Yes / No

(3)

Yes / No

Leg cramps?

Muscle aches?

Joint stiffness?

Swollen joints?

Joint pain?