



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

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?

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

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT