

**DR. TIFFANY YOUNG - PATIENT HISTORY FORM**

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Past Medical History**

Previous Physician's name: \_\_\_\_\_

Date of last exam: \_\_\_\_\_

Have you ever been hospitalized?  Yes  No

If yes, what for? \_\_\_\_\_

Have you ever been tested for hepatitis A, B or C?  Yes  No

Which hepatitis virus? \_\_\_\_\_

Have you been vaccinated for hepatitis B?  Yes  No

If yes, date vaccine series completed \_\_\_\_\_

Have you been vaccinated for hepatitis A?  Yes  No

If yes, date vaccine series completed \_\_\_\_\_

Last Tuberculosis (TB) Screening? \_\_\_\_\_

Result of TB screening:  Positive  Negative

If positive TB screen, date of last chest x-ray: \_\_\_\_\_

Result of chest x-ray:  Positive  Negative

Have you had a sexually transmitted disease?  Yes  No

Diagnosis: \_\_\_\_\_

**Which of the following conditions are you currently being treated or have been treated for in the past (please check)**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Heart disease / Murmur / Angina | <input type="checkbox"/> Shortness of breathe  | <input type="checkbox"/> Eye disorder / Glaucoma | <input type="checkbox"/> Diabetes                   |
| <input type="checkbox"/> High cholesterol                | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Seizures                | <input type="checkbox"/> Kidney / Bladder problems  |
| <input type="checkbox"/> High blood pressure             | <input type="checkbox"/> Lung problems / cough | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Liver problems / Hepatitis |
| <input type="checkbox"/> Low blood pressure              | <input type="checkbox"/> Sinus problems        | <input type="checkbox"/> Headaches / Migraines   | <input type="checkbox"/> Arthritis                  |
| <input type="checkbox"/> Heartburn (reflux)              | <input type="checkbox"/> Seasonal allergies    | <input type="checkbox"/> Neurological problems   | <input type="checkbox"/> Cancer                     |
| <input type="checkbox"/> Anemia or blood problems        | <input type="checkbox"/> Tonsillitis           | <input type="checkbox"/> Depression / Anxiety    | <input type="checkbox"/> Ulcers/colitis             |
| <input type="checkbox"/> Swollen ankles                  | <input type="checkbox"/> Ear problems          | <input type="checkbox"/> Psychiatric care        | <input type="checkbox"/> Thyroid problems           |

**Please describe any current or past medical treatment not listed above**

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**Please list your past surgeries**

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**Allergies**

Are you allergic to penicillin or any other drugs?  Yes  No

Please list: \_\_\_\_\_

**Medications**

Please list: \_\_\_\_\_

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**PLEASE COMPLETE REVERSE SIDE →**

**Social and Preventive History**

Do you currently smoke or chew tobacco? Yes No  
How many packs per day? \_\_\_\_\_

If no, have you in the past? Yes No

Do you drink alcohol, beer, or wine? Yes No  
How many drinks per week? \_\_\_\_\_

If no, have you in the past? Yes No

Do you currently drink coffee and/or tea? Yes No

If yes, how many cups per day? \_\_\_\_\_

Do you exercise daily/weekly? Yes No

Do you use seatbelts while driving? Yes No

Do you wear a helmet while riding a bike? Yes No

**Family History**

	<u>Living</u>	<u>Age (or age at death)</u>	<u>List serious illnesses</u>
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Brothers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses:

<u>Illness</u>	<u>Which family member?</u>
Anemia or Blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High blood pressure	_____
HIV disease / AIDS	_____
Mental Illness / Depression	_____
Stroke	_____
Other serious illness	_____

**Females: Gynecological History**

How many times have you been pregnant? \_\_\_\_\_

Date of last Pap Smear: \_\_\_\_\_

Have you had an abnormal Pap Smear? Yes No

Diagnosis: \_\_\_\_\_ Follow up: \_\_\_\_\_

Have you had a sexually transmitted disease? Yes No

Diagnosis: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_

Mammogram results: \_\_\_\_\_

Have you ever had a breast biopsy? Yes No

Biopsy results: \_\_\_\_\_

**By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.**

**Patient/Legal Guardian Signature** \_\_\_\_\_

**Date** \_\_\_\_\_