Caballero Family Healthcare Group PLLC

Patient History Form

Date: _____
Patient Name_____

DOB_____
Medications

List of Current Medications (include Over the Counter and Vitamins or Supplements):

_____
_____
_____

Medication Allergies and Food Allergies:

_____
_____

Surgical History:

_____
_____

Medical History:

_____
_____

Specialist:

_____
_____

Pharmacy Name and Address:

_____

Pharmacy Phone Number:

_____

Health Habits:

Health habits – Check which substances you use and describe how much you use.

- Caffeine_____
- Drugs_____
- Tobacco_____
- Alcohol_____
- Other_____

Occupational – Check if your work exposes you to the following

Your Occupation: _____

- Stress_____
- Heavy Lifting_____
- Hazardous Substance_____
- Other_____

Check symptoms you currently have or have had in the past year.

General

- Chills
- Depression/ Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of Sleep
- Numbness
- Sweats

Muscle, Joint, Bone

Pain, weakness, numbness in:

- Arms □Hips
- Back □Legs
- Feet □Neck
- Hands □Shoulders

Genito-Urinary

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

Gastrointestinal

- Appetite Poor
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive Thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

Cardiovascular

- Chest Pain
- High/Low Blood Pressure
- Irregular/Rapid Heartbeat
- Poor Circulation
- Swelling of Ankles
- Varicose Veins

Eye, Ear, Nose, Throat

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earache/Ear Discharge
- Hay Fever
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Persistent Cough
- Ringing in Ears
- Sinus Problems
- Vision – Flashes/ Halos

Skin

- Bruise Easily
- Hives
- Itching/Rash
- Change in Moles
- Scars
- Sore That Won't Heal

Men Only

- Erection Difficulties
- Lump in Testicles
- Penis Discharge
- Sore on Penis
- Date of Last:

Colonoscopy_____

Eye Exam_____

Bone Scan_____

Women Only

- Abnormal Pap Smear
- Bleeding Between Periods
- Breast Lump
- Extreme Menstrual Pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge
- Date of Last:

Colonoscopy_____

Eye Exam_____

Bone Scan_____

Mammogram_____

Menstrual Period _____

Pap Smear_____

Are you pregnant? ____

# of Children_____

Check conditions you have or have had in the past

- AIDS
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart Disease
- Hepatitis
- Herpes
- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headache
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate Problem
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease

Describe serious illnesses and/or operations _____

Date of last physical examination_____

Family History

ALIVE DECEASED	FATHER ☐ ☐	MOTHER ☐ ☐	BROTHERS/SISTERS ☐ ☐	CHILDREN ☐ ☐
Current Conditions				
Cause of Death				

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

- Diabetes
- Heart Disease
- Cancer
- Stroke
- Bleeding Tendency
- High Blood Pressure
- Kidney Disease
- Nervous Illness
- Tuberculosis
- Allergy
- Other_____

Name: _____ DOB: _____Date _____