Name: _____ Date: _____ ACCT #: _____

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Ironwood Physicians, PC

PATIENT HISTORY FORM

Reason for Consultation: _____

PRIMARY CARE PHYSICIAN: _____ **REFERRING PHYSICIAN:** _____

PAST MEDICAL HISTORY

Please check if you've been diagnosed with any of the following conditions

☐ Anemia	☐ Chronic Kidney Disease	☐ Heart Disease	☐ Hyperthyroidism	☐ Neuropathy
☐ Aneurysm	☐ Diabetes	☐ Heart Failure	☐ Hypothyroidism	☐ Osteoporosis
☐ Arthritis	☐ Emphysema/COPD	☐ Hepatitis	☐ Irregular Heart Rhythm	☐ Psychological Disorders
☐ Asthma	☐ Enlarged Prostate	☐ High Blood Pressure	☐ Liver Disease	☐ Seizures
☐ Bleeding Disorder	☐ Glaucoma	☐ High Cholesterol	☐ Lupus	☐ Stroke / TIA
☐ Blood Clots	☐ Genetic Disorder	☐ HIV/AIDS	☐ Migraines	☐ Vascular Disease

Other Medical Conditions *(Please List)***:**

☐ **Cancer** *(type)**:***	***Previous Treatment?***

Are you currently participating in a clinical trial? Yes ☐ No ☐

Please Provide Dates for:

Last Mammogram:	Last Colonoscopy:	Last Dexa Scan:	Last Flu Vaccine:	Last Pneumonia Vaccine:

SURGICAL HISTORY

Please list any surgeries that you have had and (approximate) date & facility below

_____

_____

_____

_____

SOCIAL HISTORY

Please answer all of the questions below

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____ Religious Preference: _____

Have you ever used tobacco? ☐ Yes ☐ No ☐ Current Use ☐ Past Use [Quit ____ years ago]

If so, which type(s)? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Chewing Tobacco

How much per day? _____ For how many years? _____

Do you consume alcohol? ☐ Yes ☐ No If so, what type(s)? _____

How often? ☐ Daily ☐ Weekly ☐ Socially Number of Drinks/week: _____

Do you use any recreational drugs? ☐ Yes ☐ No

Name: _____ Date: _____ ACCT #: _____

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PATIENT HISTORY FORM

REPRODUCTIVE HISTORY

For female patients only

Age at first period? _____ Number of pregnancies? _____ Number of births? _____ Age at 1st birth? _____

Have you gone through menopause? ☐ Yes ☐ No If yes, at what age? _____ Last Menstrual Cycle _____

Have you ever taken oral contraceptive pills? ☐ Yes ☐ No When: _____

Have you ever taken any medications for treatment of infertility? ☐ Yes ☐ No When? _____

Have you had a tubal ligation: ☐ Yes ☐ No When? _____

Is your flow ☐ Regular or ☐ Irregular How often? _____ How long? _____

How many pads/tampons do you use in a day? _____ Any pain, bleeding or blood clots? ☐ Yes ☐ No

Have you ever had a breast biopsy before? ☐ Yes ☐ No How many have you had? _____

If Yes, were any abnormal? ☐ Yes ☐ No Explain: _____

Have you ever taken hormone replacement therapy? ☐ Yes ☐ No When: _____

FAMILY HISTORY

Please indicate any medical problems. If deceased, indicate age and cause of death

Mother: ☐ Living ☐ Deceased Age: _____ Cause of Death: _____

Father: ☐ Living ☐ Deceased Age: _____ Cause of Death: _____

Other: _____ Age: _____ Cause of Death: _____

Adopted: ☐

Other Significant Health Conditions:

_____

_____

CANCER FAMILY HISTORY

Please indicate any family cancer.

Relative:	Type of Cancer:	Age at Diagnosis:	Lineage (Maternal or Paternal side)

Please answer these additional questions if applicaple

Is there a known hereditary cancer predisposition syndrome in your family? _____

Are you aware of prior genetic testing in any of your family members with cancer? If yes, what are the results? _____

Do you have Jewish ancestry on either maternal or paternal side? _____

To be completed by patients with bleeding or clotting problems

Is there a known hereditary bleeding or clotting disorder that runs in your family? _____

Is there a family history of blood clots or bleeding disorder? _____