Name: _____ Date: _____ ACCT #: _____

*For office use only.*

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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Ironwood Physicians, PC

# 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? _____