Concierge Family Medicine
Patient History Worksheet

Patient Name: _____ Date: _____

Do we have your **CURRENT** address and phone number?_____

List ALL medicines you are currently taking (include doses):

Are you allergic to any medications?
(Please list) _____

Since your last visit have you or any of your family members (blood relatives) been diagnosed with the following: (Please check ALL that apply)

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Trouble
- ☐ Cancer
- ☐ Ulcers
- ☐ Thyroid disease
- ☐ Arthritis/Gout
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Kidney Disease

Since your last physical have you had an overnight stay in a hospital?_____

Since your last physical have you had any kind of surgery? (List)_____

If you smoke, how many packs per day?_____

Approximate alcohol consumption?_____

Have you recently experienced any of the following:
(Please check ALL that apply)

- ☐ Weight Gain or Loss
- ☐ Muscle/Joint Pains
- ☐ Changes in your skin
- ☐ Weakness/dizziness
- ☐ Tremor
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Pain in your ears
- ☐ Difficulty hearing
- ☐ Allergies/Hay Fever
- ☐ Sinus problems
- ☐ Mouth/throat problems
- ☐ Cough
- ☐ Fever
- ☐ Chills
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Breast Pain (or lump)
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Diarrhea/Constipation
- ☐ Blood in your stool
- ☐ Hemorrhoids
- ☐ Pain when you urinate
- ☐ Discharge Penis/Vagina
- ☐ Sores on Genitals
- ☐ Menstrual Abnormalities
- ☐ Depression/Anxiety
- ☐ Mood Changes/Swings
- ☐ Sexual Desire
- ☐ Problems with Erections

List any other specific concerns or problems you wish to discuss with Dr. Jones today: