Atlantic
Medicine & Wellness

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SHANNON B. RITTBERG, DO

PATIENT PERSONAL HISTORY FORM

NAME: _____
(PLEASE PRINT)

D.O.B.: ___/___/____

Phone Number: cell:_____home:_____ bus:_____

Primary Care Physician: _____

Date of Last Physical:_____/___/_____

Pharmacy name : _____ Phone no:_____
Address:_____

Reason for your visit today: *(please list all symptoms)*

1.	2.
3.	4.

PAST MEDICAL HISTORY: *please circle all that apply*

Circulatory system:

High blood pressure	Atrial fibrillation
Heart attack	Coronary artery disease
Peripheral vascular disease	Deep vein thrombosis

Other: _____

Pulmonary system:

COPD/Emphysema	Asthma
Pulmonary Embolism	Sleep Apnea
Pneumonia	Tuberculosis
Asbestosis	

Other: _____

Gastrointestinal:

GERD	Ulcerative colitis
Crohn's disease	Irritable Bowel Syndrome
GI Bleeding	

Other: _____

NAME:_____ DOB: _____ DATE:_____

Endocrine/Metabolic:

Diabetes	Hyperlipidemia
Hypothyroidism	Hyperthyroidism
Osteoporosis	Obesity

Other: _____

Neurologic:

Stroke	TIA
Migraines	Seizure disorder
Tremors	Parkinson's disease
Dementia	Neuropathy
Vertigo	Restless leg syndrome

Hematologic:

Anemia	B12 deficiency
Thrombocytopenia	Leukemia

Other:_____

Renal:

Renal Insufficiency	Renal Failure
Kidney stones	Pyelonephritis

Other:_____

Urinary System:

BPH	Prostatitis
Incontinence	Hematuria
Erectile Dysfunction	

Other: _____

Head and Neck:

Allergic rhinitis	Chronic sinusitis
Meniere's Disease	Hearing loss
Cataracts	Glaucoma
Macular degeneration	

Other: _____

Infectious Disease:

Mononucleosis	Lyme disease
Hepatitis	HPV
Genital herpes	HIV
Chlamydia	

Other: _____

Psychiatry:

Anxiety	Depression
Attention Deficit Disorder	Bipolar Disorder
Substance Abuse	

Other:_____

NAME:_____ DOB: _____ DATE:_____

Musculosketal:

Osteoarthritis	Rheumatoid Arthritis
Lupus	Gout
Fibromyalgia	Spinal disc disease
Other:_____	

Female Health History:

Irregular Menstrual cycle	Polycystic Ovarian Syndrome
Fibrocystic breast disease	Uterine fibroids
Other:_____	

Cancer:

Breast	Lung
Colon	Renal
Thyroid	Lymphoma
Melanoma	Bladder
Other:_____	

Last mammogram:	Date:_____	Result: _____
Last PAP:	Date:_____	Result: _____
Last DEXA:	Date:_____	Result: _____
Last colonoscopy:	Date:_____	Result: _____
Pneumonia vaccine:	Date:_____	
Tetanus shot:	Date:_____	

PAST SURGICAL HISTORY:

Appendix	Joint replacement
Tonsils	Pacemaker
Gall bladder	Hysterectomy
Cardiac Catherization	
Other:_____	

ALLERGIES:

Medication:_____

Food:_____

Environmental:_____

SOCIAL HISTORY:

Do you smoke?	YES: ____packs/day	NO	DATE QUIT:_____
Caffeine:	YES:_____cups/day	NO	
Alcohol use:	YES: type:_____ amount per day:_____		NO
Substance use:	YES: type:_____ amount per day:_____		NO

NAME:_____ DOB: _____ DATE:_____

FAMILY HISTORY:

Family Member	Illness	If deceased, age at death and cause
Mother	_____	_____
Father	_____	_____
Sibling	_____	_____
Sibling	_____	_____
Child	_____	_____
Child	_____	_____
Child	_____	_____
Other	_____	_____
Other	_____	_____

MEDICATIONS: *please list all medications, including over the counter, vitamins and supplements*

Drug	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SPECIALISTS: *please include phone number*

_____
_____
_____
_____
_____
_____
_____