Atlantic
Medicine & Wellness

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PATIENT PERSONAL HISTORY FORM

NAME: _____

(PLEASE PRINT)

Date: _____/_____/_____ D.O.B.: _____/_____/_____

Preferred phone number: _____

May we leave you a detailed voicemail with results: YES/NO

Primary Care Physician: _____

Date of Last Physical: _____/_____/_____

Pharmacy name: _____ Phone no:_____

Address: _____ _____

REASON FOR YOUR VISIT TODAY:

1.	2.
3.	4.

PAST MEDICAL HISTORY: *please circle all that apply*

Circulatory system:

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

Pulmonary system:

COPD/Emphysema
Pulmonary Embolism
Pneumonia
Asbestosis
Asthma
Sleep Apnea
Tuberculosis
Other: _____

NAME:_____ **DOB:** _____ **DATE:**_____

Gastrointestinal:

GERD	Ulcerative colitis
Crohn's disease	Irritable Bowel Syndrome
GI Bleeding	Leaky Gut Syndrome
Other: _____	

Endocrine/Metabolic:

Diabetes Type I or II	Hyperlipidemia
Hypothyroidism	Hyperthyroidism
Osteoporosis	Obesity
Other: _____	

Neurologic:

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

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: _____	

NAME:_____ **DOB:** _____ **DATE:**_____

Psychiatry:

Anxiety	Depression
Attention Deficit Disorder	Bipolar Disorder
Substance Abuse	
Other:_____	

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
Prostate	
Other:_____	

PAST SURGICAL HISTORY:

Appendix	Joint replacement (please list type)
Tonsils	Pacemaker
Gall bladder	Hysterectomy
Cardiac Catheterization/Stent	
Other:_____	

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

SOCIAL HISTORY:

Do you smoke?	YES: ____ packs/day Never a smoker:_____
	FORMER SMOKER: Years smoked: _____Date quit: _____
Caffeine:	YES/NONE: _____cups/day
Alcohol use:	YES/NONE: type: _____ amount per day/week/social: _____
Substance use:	YES/NONE: type: _____ amount per day/week/social: _____

NAME:_____ **DOB:** _____ **DATE:**_____

FAMILY HISTORY:

Family Member	Living/Deceased	Age	Medical Conditions/Cause of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Son(s)/Daughter(s)	_____	_____	_____
Other	_____	_____	_____

ALLERGIES:

No Known Drug Allergies
Medication Allergies: _____
Food Allergies: _____
Environmental Allergies: _____
Other:_____

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

Drug	Dosage and directions
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

NAME:_____ **DOB:** _____ **DATE:**_____

REVIEW OF SYSTEMS: *Please check all that apply*

Constitutional

- ☐ Fever
- ☐ Malaise
- ☐ Fatigue
- ☐ Chills
- ☐ Increased Appetite
- ☐ Decreased Appetite
- ☐ Poor Sleep
- ☐ Unintentional Weight Gain
- ☐ Unintentional Weight Loss

Comments:_____

Eyes

- ☐ Vision Changes LT___Rt___
- ☐ Vision Loss LT___Rt___
- ☐ Blurred Vision LT___Rt___
- ☐ Redness LT___Rt___
- ☐ Discharge LT___Rt___

Comments:_____

Ears

- ☐ Difficulty hearing LT___Rt___
- ☐ Tinnitus LT___Rt___
- ☐ Pain LT___Rt___
- ☐ Discharge LT___Rt___

Comments:_____

Nose

- ☐ Discharge
- ☐ Congestion
- ☐ Post Nasal Drip
- ☐ Sinus Pressure
- ☐ Sneezing

Comments:_____

Mouth/Throat/Neck

- ☐ Sore Throat
- ☐ Discharge
- ☐ Swollen lymph nodes
- ☐ Comments:_____

Pulmonary **(Please circle all that apply)*

- ☐ Shortness of breath *(At rest/with exertion)
- ☐ Cough *(Dry/Wet/barking/at night/general)
- ☐ Sputum (Please list color_____)
- ☐ Wheezing
- ☐ Noisy Breather

Comments:_____

Cardiovascular

- ☐ Chest Pain (Please describe_____)
- ☐ Palpitations
- ☐ Shortness of breath while laying flat
- ☐ Shortness of breath that wakes you from sleep
- ☐ Pain in legs while walking
- ☐ Ankle swelling

Comments:_____

Gastrointestional **(Please circle all that apply)*

- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation *(intermittent or continuous)
- ☐ Change in bowel habits *(Pain or Bleeding)

Comments:_____

NAME:_____ **DOB:** _____ **DATE:**_____

Urinary

- ☐ Painful urination
- ☐ Blood in urine
- ☐ Urinating frequently at night
- ☐ General urgency
- ☐ General frequency

Comments:_____

Female Genital

- ☐ Pregnant
- ☐ Vaginal Discharge
- ☐ Abnormal Bleeding
- ☐ Genital sore/lesion

Comments:_____

Male Genital

- ☐ Penile discharge
- ☐ Erectile dysfunction
- ☐ Testicular dysfunction
- ☐ Testicular/scrotal Mass
- ☐ Testicular/scrotal Pain
- ☐ Genital Sore/lesion

Comments:_____

Breast

- ☐ Pain
- ☐ Mass
- ☐ Nipple Discharge

Comments:_____

Musculoskeletal **(please list location)*

- ☐ Joint pain _____
- ☐ Muscle Pain _____
- ☐ Swelling _____
- ☐ Stiffness _____
- ☐ Back pain
- ☐ Neck pain
- ☐ Cramps at night
- ☐ Muscle spasms
- ☐ Injury _____

Comments:_____

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Sleep Apnea Questionnaire

Epworth Sleepiness Scale

How likely are you to sleep or doze in each of the following situations?

0- no chance, 1-slight chance, 2-moderate chance, 3-high chance

0 1 2 3 Sitting and Reading
0 1 2 3 Watching TV
0 1 2 3 Sitting Inactive In A Public Place (e.g. Movie or Meeting)
0 1 2 3 As A Passenger In A Car For An Hour Without A Break
0 1 2 3 Lying Down To Rest In The Afternoon When Circumstances Permit
0 1 2 3 Sitting And Talking To Someone
0 1 2 3 Sitting Quietly After A Lunch Without Alcohol
0 1 2 3 In A Car, While Stopped For A Few Minutes In Traffic

Epworth Total= ☐

Health Symptoms

Please answer the following question about your sleeping habits.

Yes No Have you ever been told you stop breathing while asleep?
Yes No Have you ever fallen asleep or nodded off while driving?
Yes No Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?
Yes No Do you feel excessively sleepy during the day?
Yes No Do you snore or have you ever been told that you snore?
Yes No Have you had weight gain and found it difficult to lose?
Yes No Have you taken medication for, or been diagnosed with high blood pressure?
Yes No Do you kick or jerk your legs while sleeping?
Yes No Do you feel burning, tingling, or crawling sensations in your legs when you wake up?
Yes No Do you wake up with headaches during the night or in the morning?
Yes No Do you have trouble falling asleep?
Yes No Do you have trouble staying asleep once you fall asleep?

Health Symptom Total= ☐ *(One Point for Each "Yes" Answer)*

Previous Medical Diagnoses

Please check any conditions for which you have been medically diagnosed or treated.

☐ Heart Failure
☐ Hypertension
☐ Metabolic Syndrome
☐ Heartburn
☐ Stroke
☐ Diabetes
☐ Obesity
☐ Atrial Fibrilation

Medical Diagnoses Total= ☐ *(Two Points for Each Selected Diagnoses)*

****Please Add Together All Three Totals To Assess Your Sleep Apnea Risk=*** ☐