Queen City Physicians Patient History Form

Patient Name ______________________ Date of Birth ______________ Gender ______

Height __________ Weight __________ lbs

Reason for Today's Visit ______________________________

Primary Care Physician ______________________

Any other Physician(s) you are currently seeing ______________________________

List all known allergies ______________________________

List all prescription and over-the-counter medications you are currently taking (please include vitamins and herbals

Type Here

List all prior hospitalizations or surgical procedures, serious accidents, or chronic illnesses/ conditions

Type Here

Do/Did you use tobacco? ________ How long? ____________ Amount ______ packs per week

Do/Did you consume alcohol? ______ How long? ____________ Amount ________ per week

Do/Did you drink coffee? ________ How long? ____________ Amount ______ cups per week

Do you wear a seatbelt? ________

Have you received a bloodtransfusion ? ________ If so, when? ______________________

Do you have a living will ? ________ Do you have a power of attorney ? ________

Have you ever been diagnosed with any of the following conditions?

☐ Anemia ☐ Anxiety ☐ Asthma ☐ Cancer ____________ (specify) ☐ COPD

☐ Cardiac Disease ____________ (specify) ☐ Depression ☐ Diabetes Mellitus Type I ☐ Diabetes Mellitus Type II

☐ Hyperlipidemia ☐ Hypertension ☐ Migraines ☐ Osteoporosis ☐ Thyroid Disease ____________ (specify)

Please list any other conditions you've been diagnosed with ______________________________

Women Only

Date of Last Menstrual Period ________ # of Pregnancies ________ Oral Contraseptives ______

Family History

	Name	Living/Deceased	Age now/ at death	Cause of death	History of illness
Mother					
Father					
Sibling/ Child					
Sibling/ Child					
Sibling/ Child					
Sibling/ Child					
Sibling/ Child					
Sibling/ Child					
Sibling/ Child					