Thomas X. Minor, M.D. & Nadeem Rahman, M.D.

Patient History Form

NAME: ______________________________________

DATE: ______________________________________

CHIEF COMPLAINT: In your own words, why are you seeing the doctor today?

____

____

How long has this problem been present? Have recent tests been performed for this problem?

____

What facility were these tests performed at? ____

PAST MEDICAL AND SOCIAL HISTORY:

Do you currently smoke? ______Yes ______No How many packs? _____________ How many years? ____________

Have you ever smoked? ______Yes ______No How many packs? _____________ How many years? ______________

Have you ever quit smoking? ______Yes ______No For how long? _______________

Marital Status: ______Single ______Married ______Widowed ______Divorced

Children? ______Yes ______No How many? ________

Do you drink alcohol? _______Never ________Rarely _______ Moderately _______Heavily

Occupation? ____

ALLERGIES TO MEDICATIONS AND REACTIONS:

____

____

____

CURRENT PRESCRIPTIONS MEDICINES YOU TAKE ON A REGULAR BASIS:

____ ____

____ ____

____ ____

LIST AND DATE ANY PREVIOUS SURGERIES YOU HAVE HAD:

____

____

____

DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE?

______ Diabetes ______ Bladder Cancer _______ Tuberculosis

______ High Blood Pressure _______ Prostate Cancer _______ Heart Disease

______ Kidney Stones _______ Colon/Rectal Cancer _____ Other: ________________________

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