

Patient History Form

Date		Time	
Patient Name			
Address			
City	State	Zip	
Phone #		Cell #	
Contact Name		Phone #	

Date of Birth	Sex	Social Security
	Male <input type="checkbox"/> Female <input type="checkbox"/>	

Physicians	Name	Phone	City/State
Primary Care Dr			
Referring Dr			
Diabetic Dr			
Surgeon			

Home Health:	Phone #:	Contact Person:	Date Service Began:
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Name of Pharmacy:	Phone #:
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Please list any medications that you are currently taking or attach a list.

Name of Medication	Quantity(amount per day)	Actively Taking

Please list any allergies.

Allergies:

Chronic Illness	Onset Date	Active	Inactive

Hospitalizations	approx. Year	Physician or Facility

Surgeries/Procedures	approx. Year	Physician or Facility

Past Family and Social History

Marital Status			
Single <input type="checkbox"/>	Married <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widow <input type="checkbox"/>

Work History	
Occupation:	
Retired Because:	
Present Activity	

Living Conditions			
Alone <input type="checkbox"/>	With Family <input type="checkbox"/>	Nursing Facility <input type="checkbox"/>	Other <input type="checkbox"/>

Needs	
Patient has family or a friend who can assist with care?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Needs Home Health Assistance?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Health Habits			
Do you smoke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Amount:
Alcohol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Amount:
Coffee?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Amount:
Recreational Drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Amount:
Other Note:			

Family Members Cause of Death		
Mother:	Father:	Children:

ulcer/wound location, duration, treatment
level of pain :