

Patient History Form

Date: _____

East Springdale Family Clinic
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Patient's Name: _____ Date of Birth: _____

Briefly describe what problem(s) brings you to the doctor: _____

List all your medications (including: the dosage, frequency, and any non-prescription medications you take).

MEDICATION ALLERGIES
1. _____
2. _____
3. _____
4. _____

Past Medical History: please place an X if you or your family has ever had any of the following:

Diabetes: You Family Psychiatric Problems: You Family Heart Disease: You Family
Thyroid: You Family High Blood Pressure: You Family Liver Function: You Family
Seizures: You Family Lung Disease: You Family Kidney Disease: You Family
TB: You Family Kidney Stones: You Family Urine Infection: You Family
Cancer: You Family Bleeding Problems: You Family Infertility: You Family
Type of Cancer: _____ Anesthesia Problems: You Family

List gynecological history: Last Menstrual Period: _____ # of Pregnancies _____ # Live Births _____

List surgical history:

Surgery	Date	Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family medical history:

Disease or Cause of Death

Father: Age _____ Living Deceased _____
Mother: Age _____ Living Deceased _____
Brother: Age _____ Living Deceased _____
Brother: Age _____ Living Deceased _____
Sister: Age _____ Living Deceased _____
Sister: Age _____ Living Deceased _____

Social History:

Single Married Divorced Widowed

Occupation: _____

Religion: _____

Do you use or have you ever used tobacco?

No Yes, how much _____

If quit, when? _____

Immunizations: Last tetanus shot _____ Pneumonia Vaccine _____ Flu Shot _____

If patient is a child, are immunization up to date? _____

Please see the other side →

REVIEW OF SYSTEMS:

DO YOU NOW OR HAVE YOU RECENTLY HAD PROBLEMS WITH ANY OF THE FOLLOWING?
(PLEASE CIRCLE YOUR ANSWERS)

GENERAL	Change in weight	Fever			
GENITAL/URINARY SYSTEM	Pain or burning with urination	Kidney stone	Frequency	Slow or small stream	Blood in urine
	Getting up at night to urinate	Leaking of urine	urgency	Poor bladder emptying	Recurrent urine infections
	Abnormal vaginal bleeding	Menstrual problems	Sexual problems		
SKIN	Lumps or nodules	Breast lump	rashes	sores	Other skin problems
EYES	glaucoma	cataracts	glasses	Other eye problems	
EARS, NOSE & THROAT	Trouble swallowing	Nose bleeds	dentures	Sinus problems	Earaches
BLOOD/LYMPH	Swollen nodes or glands	Bleeding problems	anemia	Other blood disorders	
HEART & VASCULAR	Irregular heart beat	Heart failure	angina	Heart valve problems	Heart murmur
	Pain in legs with exertion	Chest pain	phlebitis	Swelling in legs	Blood clots
	Other heart/blood vessel problems				
RESPIRATORY	Shortness of breath	wheezing	cough	asthma	Other lung problems
GASTROINTESTINAL	Gallbladder problems	Blood in stool	diarrhea	Dark tarry stools	Intestinal bleeding
	Poor appetite	Hiatal hernia	ulcer	indigestion	Hemorrhoids
	constipation	vomiting	nausea	hernia	
NEUROLOGICAL	Loss of consciousness	headaches	strokes	dizziness	paralysis
	numbness	Weakness			
PSYCHOLOGICAL	Other psychological problems	depression	Anxiety		
MUSCULOSKELETAL	Joint replacement surgery	Broken bones	gout	arthritis	Bone or joint pain
ENDOCRINE	Heat or cold intolerance	Hot flashes	flushing	Abnormally thirsty	Skin pigmentation change