HIGHLAND CLINIC

FAX FORM TO 4451

DATE:_____ PATIENT HISTORY FORM PCP / REFERRING MD

_____

Name:_____DOB:_____Age:_____

Reason for Visit:_____Doctor_____

Review of Systems: ***Do you have?***

☐ Fever	☐ Ear Ache	☐ Neck Pain	☐ Heartburn	☐ Cold/Heat
☐ Chills	☐ Ear Drainage	☐ Thyroid Nodule	☐ Nausea	Intolerant
☐ Fatigue	☐ Nasal Discharge	☐ Swollen Glands	☐ Vomiting	☐ Easy Bruising/Bleeding
☐ Weight change	☐ Post Nasal Drip	☐ Skin Growth/Sores	☐ Diarrhea	☐ Transfusion
☐ Night Sweats	☐ Stuffy Nose	☐ Rash	☐ Headache	☐ Immunocompromised
☐ Visual loss	☐ Nose Bleeds	☐ Itching	☐ Migraines	☐ Anemia
☐ Itchy Eyes	☐ Sneezing	☐ Skin/Hair/Nail Changes	☐ Fainting	☐ Blood Clots
☐ Tearing	☐ Dental Problems	☐ Chest Pain	☐ Numbness	☐ Snoring
☐ Blurred/Double Vision	☐ Tonsillitis	☐ Palpitations	☐ Weakness	☐ Apnea
	☐ Mouth Sores	☐ Swelling Hands/Feet	☐ Slurred Speech	
☐ Vertigo	☐ Hoarseness	☐ Wheezing	☐ Nervousness	
☐ Dizziness	☐ Voice Changes	☐ Coughing up Blood	☐ Anxiety	☐ Insomnia
☐ Ringing Noise	☐ Problems Swallowing	☐ Chronic Cough	☐ Depression	☐ daytime tiredness
☐ Hearing Loss	☐ Throat Pain	☐ Shortness of Breath	☐ Excessive Thirst/Urination	

Past Medical History: *Have you had?*

☐ None
☐ Cancer – Specify_____
☐ Gerd / Reflux ☐ Depression/Anxiety ☐ Thyroid Disease
☐ COPD / Emphysema ☐ Liver Disease ☐ Heart Attack
☐ Diabetes ☐ Kidney Disease ☐ Allergy / Hayfever
☐ Osteoporosis ☐ Asthma
☐ Arthritis ☐ Mitral Valve Prolapse Other _____
☐ High Blood Pressure ☐ High Cholesterol _____

Past Surgical History:

Have you had?	*Year*
☐ Thyroid	____
☐ Appendectomy	____
☐ Hysterectomy	____
☐ Gallbladder	____
☐ Tonsillectomy	____
☐ Wisdom Teeth	____
☐ Other_____	
☐ None	

Family History: *Please indicate family member*

☐ High Blood Pressure ☐ Rheumatologic Disease
☐ Heart Disease ☐ None
☐ Depression
☐ Diabetes
☐ Bleeding Problems
☐ Cancer – Specify _____
☐ Other _____

Social History: Marital Status _____

Occupation:_____

☐ None
☐ Tobacco Use Yes No___Pks/Day
☐ Former Tobacco Use Yes Year Quit: _____
☐ 2nd Hand Smoke Yes No
☐ Alcohol Use Yes No
☐ Drug Use Yes No

Allergies: _____

Medications: *Drug Name Dose/Strength/Directions* Do you take blood thinners? ☐ Yes ☐ No

All patients please complete medication list. Additional meds can be listed on the back of this sheet.

_____ _____
_____ _____
_____ _____
_____ _____