

PATIENT HISTORY

Patient name:	DOB:	Today's date:
Reason for your visit to our office:		
Describe your current illness/symptoms:		

SOCIAL HISTORY

Occupation:	Employer:	Retired <input type="checkbox"/>
Marital status: Married <input type="checkbox"/> Spouses name: _____ Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>		
Primary Language: English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Other languages spoken:	**Education level:	
Ethnicity:	Race:	

ALCOHOL CONSUMPTION

Alcohol use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Drinks per week? Glasses of Wine ____ Cans of beer ____ Shots of liquor ____ Drinks containing 0.5 oz ____ Other: _____		
Have you ever had more than 4 drinks in a day?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
How many times in the last 12 months?	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> + ____	

TOBACCO USE

Tobacco use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If so are you ready to quit?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="checkbox"/> Current tobacco smoker Age started: ____ Packs/day: ____		
<input type="checkbox"/> Former smoker Age started: ____ Quit date: _____		
Smokeless tobacco use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="checkbox"/> Current smokeless tobacco smoker: Age started: ____ Frequency: Daily ____ Weekly ____ Monthly ____		
<input type="checkbox"/> Former smokeless tobacco smoker: Age started: ____ Quit date: _____		

DRUG USE

Drug use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Type of drug(s) _____ Age started: ____ Frequency: Daily ____ Weekly ____ Monthly ____		
<input type="checkbox"/> Current use <input type="checkbox"/> Former use Quit date: _____		
Comments:		

SOCIAL/SPIRITUAL ASSESSMENT

Are you being emotionally or physically abused?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comment:		
Is your care being neglected?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comment:		
Do you have specific needs or concerns about your illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comment:		
What forms of support to you have? Family <input type="checkbox"/> Friends <input type="checkbox"/> Faith <input type="checkbox"/> Other: _____		

FAMILY HISTORY

Relationship	Alive?	Alcohol abuse	Arthritis	Asthma	Autoimmune disorder	Cancer	COPD/Emphysema	Diabetes	Heart disease	High Cholesterol	High blood pressure	Kidney disease	Learning disability	Mental illness	Stroke	Vision loss	Other/Comment
Mother	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Father	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sister/Brother	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child(dren)	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandparents	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandparents	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Family History:																	

MEDICAL HISTORY

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> Memory Problems
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Mental Illness:
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Nerve/muscle disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> GERD	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer:	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Chest pain	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> CHF	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Clotting disorder	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Transplanted organ
<input type="checkbox"/> COPD	<input type="checkbox"/> Implants:	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Deafness	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Migraines
Other Medical History:		

ALLERGIES	
Medication/Food	Reaction

OTHER PROVIDERS: First AND Last name	
Primary care provider:	Pain management:
Digestive Specialist:	Dermatologist:
Endocrinologist:	Oncologist:
Urologist:	Radiation oncologist:
Kidney specialist:	Dentist:
Heart specialist:	Other:
Lung specialist:	Other:
Neurologist:	Other:

Are you interested in signing up for our Patient Portal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
--	------------------------------	-----------------------------

PERSONS INVOLVED IN YOUR CARE		
<p>The HIPPA Final Privacy Rule provides you with the right to agree or object to the use or disclosure of information to a family member or close friend who is involved in your care. I understand that Norton Thoracic Institute will refuse to discuss my information with anyone <u>NOT</u> listed below, except in an emergency. I also understand that this does not apply to medical providers. I can edit this list at any time by providing a written request to the practice. Please print:</p>		
Name	Contact number	Relationship

Patient signature: _____ Date: _____