WISDO FAMILY MEDICINE

James John Wisdo, D.O., P.A.

PATIENT HISTORY FORM

NAME _____ DATE: _____

Have you ever had or do you now have any of the following? Please answer all items.

		Mini Stroke		Heart Attack		**Males Only:**	
Anemia (low blood)		Chronic Cough		Stroke		Difficulty Starting Stream	
German Measles		Coughing Blood		Kidney Stones		Discharge from Penis	
Rheumatic Fever		Pleurisy/Pneumonia		Blood in Urine		Slowing of Urinary Stream	
Swollen/Painful Joints		Pain or Pressure in Chest		Arthritis/Rheumatism		Decreased Sex Drive	
Mumps		Palpitations		Bursitis		Venereal Disease	
Frequent Headaches		High/Low Blood Pressure		Frequent Backache		**Females Only:**	
Dizziness of Fainting		Leg Cramps		Paralysis or Double Vision		Vaginal Discharge	
Eye Trouble		Heart Murmur		Seizures or Convulsions		Painful Periods	
Nose Bleeds		Swelling of Feet and Hands		Numbness or Tingling		Vaginal Itching	
Decreased Hearing		Frequent Indigestion		Frequent Trouble Sleeping		Bleeding after Intercourse	
Ringing in Ears		Abdominal Pain		Depression or Anxiety		Menopause	
Ear Infections		Ulcers		Kidney/Bladder Infections		Hormone Therapy	
Chronic or recurrent colds		Belching or Gas		Loss of Memory/Amnesia		Decreased Sex Drive	
Severe tooth/gum trouble		Constipation or Diarrhea		Nervous Trouble		Abnormal Pregnancy	
Sinusitis/Post Nasal Drip		Change in Bowel Habits		Puffiness of the Eyes		Miscarriages	
Hay Fever/Asthma		Rectal Bleeding/Pain/Itching		Perspire or feel cold easily		Irregular Periods	
Goiter		Vomiting Blood/Black Stools		Excessive or poor appetite		Decrease of Periods	
Tuberculosis		Jaundice/Gallbladder Disease		Recent weight gain or loss		Female Periods	
Soaking Sweats/Fever		Tumor/Growth Cysts		Get up Nights to Urinate		Date of Last Period	
Difficulty Swallowing		Rupture/Hernia		Bleeding gums/easily bruise		**Quantity**	
Hoarseness/Wheezing		Frequent or Painful Urination		Skin rashes, lumps or moles		Normal _____ Heavy	
Shortness of Breath		Allergies		Cancer		Light	

SOCIAL HISTORY

Do you drink alcohol? _____

If yes, how many drinks per week? _____

_____

Do you use or have used tobacco in any form? _____

If yes, what form? _____

For how long? _____ Pack per day _____

Have you quit _____ If so, when? _____

Are you allergic to any medications? _____

If yes, explain: _____

_____

_____

Do you have any difficulty taking medications or following drug instructions? _____

_____

If yes, explain: _____

FAMILY HISTORY

Relation:	Living?/Age/Health Status	Deceased?/Cause/Age
Father	Y/N_____	Y/N_____
Mother	Y/N_____	Y/N_____
Brother(s)	Y/N_____	Y/N_____
Sister(s)	Y/N_____	Y/N_____
Children	Y/N_____	Y/N_____

Has anyone in your family had any of the following?

	No	Yes	Relation
Asthma, hay fever			
Tuberculosis			
Diabetes			
Cancer			
Kidney Trouble			
Heart Trouble			
Stomach Trouble			
Rheumatism			
High Blood Pressure			
Mental Condition			

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Name: _____

HEALTH MAINTENANCE INFORMATION

When was your last: Date

General physical examination _____

Blood test _____

EKG _____

Chest X-ray _____

Pap Smear and pelvic exam _____

Prostate check _____

Sigmoidoscopy _____

Tetanus Booster _____

Oral Polio Vaccine _____

Tuberculin Skin Test _____

Mammogram _____

Result _____

Please list all surgeries and the dates

Year Procedure

Please list any other injury, hospitalization, or disease not already noted, including x-rays

Year Event

BRING ALL MEDICATIONS YOU ARE TAKING, BOTH PRESCRIPTION AND OVER-THE-COUNTER TO ALL APPOINTMENTS WHEN SEEING THE DR.

Allergies