



East Clinic
1821 S. Stoughton Road
Madison, WI 53716

PATIENT HISTORY

Dear Patient:

Welcome to Dean East Clinic. Please take a moment to fill out this medical history form so that your physician can get better acquainted with your medical history. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

If you are new to this clinic, who was your previous primary care physician? _____

PAST MEDICAL HISTORY:

1. Please list any active medical problems for which you are currently being treated, such as hypertension, diabetes, high cholesterol, asthma, seizures.

2. Please list your surgeries with the date(s) _____

3. Please list your non-surgical hospitalizations with the date(s)

4. Please list any major accidents or injuries with the date(s) _____

PREVENTIVE INFORMATION

Have you ever had (and date):

Flu Vaccine _____ Hepatitis-B Vaccine _____

Pneumonia Vaccine _____ Tetanus Vaccine _____

Do you use seat belts? Always Sometimes Never

Do you have smoke detectors in your home/apartment? Yes No

Do you have a loaded firearm in your home/apartment? Yes No

If yes, how is it stored? _____

(Note: this question is only intended to raise awareness about safe storage of firearms)

WOMEN: When was your last:

Pap smear _____ Mammogram _____

Bone density study _____ Do you perform self breast exams regularly? Yes No

SOCIAL HISTORY / LIFESTYLE:

Where were you born and raised? _____ How long have you been in this area? _____

Do you still drive an automobile? Yes No

Marital status? (Please check) Single Married Widowed Divorced Separated

Who lives at home with you? _____

Occupation? _____ Your hobbies? _____

– Please continue on reverse side –

PATIENT PHYSICAL HISTORY (Page 2)

SOCIAL HISTORY / LIFESTYLE (continued):

Do you ride a motorcycle / bicycle? Yes No
If yes, do you wear a helmet? Always Sometimes Never

Do you smoke or use nicotine products? Yes No How many years? _____
 Cigarettes (# Packs / day) _____ Cigars Pipe Chew tobacco

Have you ever used recreational drugs? Yes No
If yes, when was the last time? _____ What kind did you use? _____

Do you take over-the-counter medication (such as aspirin, antacids, vitamins, herbal products, cold preparations) more than once a week? Yes No; If yes, which ones and how often? _____

Do you take calcium supplements? Yes No; How many servings of milk, cheese, cottage cheese, yogurt or calcium-fortified orange juice do you consume daily? _____

Do you take something to help you sleep more than once a week? Yes No _____

Do you restrict your diet in any way? (such as low calorie, low fat, no added salt, etc.?) Yes No _____

FAMILY HISTORY:

How many children do you have? None Sons _____ Daughters _____

Are all alive and in good health? Yes No; If no, please explain: _____

How many siblings do you have? None Brothers _____ Sisters _____

Are they alive and well? Yes No
If no, please explain: _____

Is your mother still living? Yes No;
If yes, major health problems / If no, cause of death _____

Is your father still living? Yes No
If yes, major health problems / If no, cause of death _____

Is there a family history (father mother, sister, brother, or children) of:

- Diabetes Depression
- High Cholesterol Suicide
- Heart Attacks before age 65 Alcoholism / Drug Abuse
- Cancer (Prostate, Skin, Breast, Colon, Ovarian)

SYSTEMS REVIEW:

GENERAL – Have you noticed:

Significant weight change (> 10#) in the past 6 months? If yes, Increase Decrease

Significant recent appetite change? If yes, Increase Decrease

Significant sweating or night sweats? Yes No

SKIN – Have you had:

Recent rashes, lumps, or other skin / hair / nail problems? Yes No

A history of skin cancer? Yes No

PATIENT PHYSICAL HISTORY (Page 3)

SYSTEMS REVIEW (continued):

EYES – Have you had:

Recent vision changes? Yes No Last eye appointment: _____ With whom? _____
Glaucoma/Cataracts? Yes No

EARS / NOSE / MOUTH / THROAT – Have you had:

Hearing Problems? Yes No; Do you have / use hearing aides? Yes No

Frequent wax impaction? Yes No

Frequent nosebleeds? Yes No

Do you have a history of Obstructive Sleep Apnea? Yes No If yes, do you use CPAP? _____

Do you snore so loudly that your bed partner complains about it? Yes No

Do you have excessive daytime fatigue? Yes No

Do you notice SIGNIFICANT dizziness, vertigo? Yes No

CARDIOVASCULAR

Do you get:

Chest pain / pressure / tightness / squeezing? Yes No

If yes, does it occur with activity or exertion? Yes No

Heart fluttering / flip-flops / skipping or palpitations? Yes No

Swelling of ankles? Yes No

Pain in legs while walking? Yes No

How far can you walk before you get short of breath? Feet Blocks Miles Unlimited

Do you take antibiotics before dental work? Yes No

Do you exercise on a regular basis (more than 2x per week)? Yes No

If yes, what type of exercise? _____ How often? _____

RESPIRATORY – Have you ever been told that you have:

Asthma? Yes No

Emphysema/chronic bronchitis? Yes No

Blood clots in your leg or lung? Yes No

Tuberculosis (TB) or positive TB skin test? Yes No

Do you notice **frequent**:

Wheezing / Shortness of breath? Yes No

Coughing / Phlegm production? Yes No

Coughing up blood? Yes No

GASTROINTESTINAL – Do you notice:

Frequent nausea or vomiting? Yes No

Frequent diarrhea? Yes No

Significant constipation? Yes No

Bloody or black bowel movements? Yes No

Frequent heartburn / regurgitation / indigestion? Yes No

PATIENT PHYSICAL HISTORY (Page 4)

GASTROINTESTINAL (continued):

- Do you take antacids or acid blocking agents more than once/week? Yes No
Trouble swallowing / Food getting stuck? Yes No
Have you ever been diagnosed with: Ulcers Hepatitis Colitis
Have you ever had a colonoscopy? Yes No
If yes, when _____

GENITOURINARY – Do you notice:

- Burning / frequency or hesitation with urination? Yes No
Do you wake up more than 2 times /night to urinate? Yes No
Do you have significant difficulty starting your urine stream? Yes No
Dribbling after urination or problems holding your urine? Yes No
Do you have to wear a pad for incontinence more than once/week? Yes No
Have you ever had kidney stones? Yes No
If yes, when was your last episode? _____
Problems with your sex drive? Yes No
Have you ever had a sexually transmitted disease? Yes No
If yes, what type(s)? Syphilis Gonorrhea Chlamydia Warts
Are you sexually active Yes No; If yes, with: Women? Men? Both?
How many sexual partners have you had in the last 6 months? _____
What kind of birth control do you use? Condoms Pills IUD Diaphragm
 Tubal ligation Vasectomy None Other _____
Do you use condoms? Always Most of the time Rarely Never
Have you ever been physically or sexually abused? Yes No
Would you like to discuss this further? Yes No
Do you feel safe in your current home/environment? Yes No

WOMEN: – Do you have or have you had:

- Problems related to menopause/change of life? Yes No
An abnormal Pap smear? Yes No; If yes, when _____
An abnormal mammogram? Yes No; If yes, when _____
Breast discharge, masses, or cancer? Yes No

MEN:

- Do you have difficulty with erections? Yes No
Would you like to discuss this further? Yes No

MUSCULOSKELETAL – Do you have or have you had:

- Significant joint pains or arthritis? Yes No If yes, which joints bother you most? _____
Gout? Yes No; If yes, last episode _____
Significant neck pain that bothers you most days? Yes No
Significant low back pain that bothers you most days? Yes No

PATIENT PHYSICAL HISTORY (Page 5)

NEUROLOGICAL – Do you have or have you had:

- Tremors / shakes? Yes No
- Significant memory problems? Yes No
If yes, does it interfere with functioning? Yes No
- A significant fall in the past year? Yes No
- Seizures? Yes No
- Significant headaches – severe enough to make you go home from school or work? Yes No
- Blackouts / fainting spells? Yes No
If yes, when was your last fainting spell? _____
- Significant numbness / tingling noted on a daily basis? Yes No
If yes, where is the numbness/tingling noted? _____

MENTAL / EMOTIONAL

- In the last 2 weeks, have you felt down, depressed, or hopeless? Yes No
- Have you recently had little interest or pleasure in doing your day to day activities? Yes No
- Have you ever had depression so severe that you considered suicide? Yes No
- Do you feel that you worry excessively to the point where you feel your muscles tighten and/or can't sleep? Yes No

Do you drink alcohol? Not at all Occasionally Daily

If you drink alcohol, on any single occasion in the past 3 months have you had more than 5 drinks containing alcohol? Yes No

If yes: On how many days per week do you drink alcohol? _____

On a typical day when you drink, how many drinks do you have? _____

What is the maximum number of drinks that you had on any given day in the past month? _____

Have you seen a psychiatrist or therapist in the past? Yes No

When were you last seen? _____ By whom _____

HEMATOLOGIC / LYMPHATIC & ALLERGIC / IMMUNOLOGIC – Have you had:

- Anemia? Yes No
- Problems with your spleen or had your spleen removed? Yes No
- Bleeding or clotting problems? Yes No
- Easy bruising? Yes No

Do you have:

Seasonal allergies/hay fever? Yes No

If yes, do you take something for this? _____

Food, latex or drug allergies? Yes No

If yes, from what food and/or drug with what type of reaction? _____

Have you ever seen an allergist Yes No

SOCIAL:

- Do you have a Durable Power of Attorney (DPA) for Health Care, Living Will or other Advanced Directives? Yes No
Would you like information regarding this? Yes No
- Do you have any other questions or would you like any information about a specific health related topic?

Thank you for taking the time to complete this questionnaire. It helps us provide the best possible health care for you.