DR. MICHAEL E. CASSER
PATIENT HISTORY RECORD

Last Name:_____ First Name: _____

Date of Appointment: ____/____/____

Address:_____

City: _____ State: _____ ZIP Code: _____

Social Security Number: _____

Referred by: _____

Pharmacy: _____

Pharmacy Phone Number: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Emergency Contact Address: _____

Emergency Contact Relationship to You: _____

The information you provide today is very important in regards to your healthcare. Please answer the following questions carefully and thoroughly to the best of your ability.

Reasons for today's visit:

_____

_____

_____

Other physicians you are currently seeing:

_____

Patient Name:_____

_____

_____

Do you see a chiropractor, massage therapist, therapist, faith healer, practitioner of homeopathy, and/or others? If so, please list them.

_____

_____

_____

Prescriptions you are currently taking:

_____

_____

_____

_____

_____

_____

Non-prescription medications including pain relievers, vitamins, herbs and any non-traditional medications:

_____

_____

_____

_____

_____

_____

Medication allergies:

_____

Patient Name:_____

_____

_____

Other allergies:

_____

_____

_____

PAST MEDICAL HISTORY

Please check any conditions you have or have ever had

___ Allergies	___ Anemia	___ Anxiety
___ Arthritis	___Asthma	___ Blood clots
___ Blood transfusion	___ Bone density test (date ___/___/___)	___ Breast masses
___ Cancer	___ Colon disease	___ Colonoscopy (date ___/___/___)
___ Depression	___ Diabetes	___ Emphysema
___ Excessive bleeding	___ Glaucoma	___ Heart attack
___ Heart disease	___ High blood pressure	___ High cholesterol
___ HIV/AIDS	___ Liver disease/Hepatitis	___ Pneumonia
___ Prostate disease	___ Rheumatic fever	___ Seizures
___ Sexually transmitted disease	___ Splenectomy	___ Stomach disease
___ Stroke	___ Thyroid disease	___ Tuberculosis
___ Other		

Patient Name:_____

Please all hospitalizations, medical and surgical procedures as well as their dates.

_____

_____

_____

_____

_____

_____

VACCINATIONS

When did you last have a tetanus shot? _____ /_____ /_____

Have you had a flu shot this year? ( ) Yes ( ) No Date: _____ /_____ /_____

Have you had the pneumonia vaccine? ( ) Yes ( ) No Date: _____ /_____ /_____

Have you been exposed to tuberculosis? ( ) Yes ( ) No Date: _____ /_____ /_____

Date of last tuberculosis skin test: _____ /_____ /_____

Skin test results: ( ) Positive ( ) Negative

If you were born after 1956, have you received a second MMR vaccine?

( ) Yes ( ) No Date: _____ /_____ /_____

Have you had the Hepatitis A vaccine (2 injections)?

( ) Yes ( ) No Date: _____ /_____ /_____

Have you had the Hepatitis B vaccine (3 injections)?

( ) Yes ( ) No Date: _____ /_____ /_____

Have you had the chickenpox? ( ) Yes ( ) No Date: _____ /_____ /_____

Patient Name:_____

Have you had the chickenpox vaccine? ( ) Yes ( ) No Date: _____ /_____ /_____

Have you had the shingles vaccine? ( ) Yes ( ) No Date: _____ /_____ /_____

Have you had the HPV vaccine (Gardasil)? ( ) Yes ( ) No Date: _____ /_____ /_____

SOCIAL HISTORY

Occupation: _____ Employer: _____

Education (Highest level completed): _____

Marital status: _____

Spouse's name: _____

Spouse's employer: _____

Religious preference, if any: _____

Do you smoke? ( ) Yes ( ) No Have you ever smoked? ( ) Yes ( ) No

Age started: _____ Age stopped: _____ How many packs per day? _____

Are you interested in stopping smoking? _____

Do you drink alcohol? ( ) Yes ( ) No How many drinks per week? _____

Are you concerned about your drinking? ( ) Yes ( ) No

Do you feel the need to cut down? ( ) Yes ( ) No

Do you presently use drugs? ( ) Yes ( ) No Have you ever used drugs? ( ) Yes ( ) No

Do you examine your skin regularly? ( ) Yes ( ) No

Do you use sun protection? ( ) Yes ( ) No

Patient Name:_____

Do you use a seat belt? ( ) Yes ( ) No

Do you exercise? ( ) Yes ( ) No

Type of exercise: _____

Frequency and duration of exercise: _____

Hobbies: _____

Have you been hurt or threatened by someone within the past year? If so, please explain:

_____

_____

_____

At any time, has someone hit, kicked, or otherwise hurt or frightened you?

_____

_____

_____

Family history:

Father

Current age : _____ OR Age at death: _____

Illnesses: _____

Cause of death: _____

Mother

Patient Name:_____

Current age : _____ OR Age at death: _____

Illnesses: _____

Cause of death: _____

Siblings

Current age : _____ OR Age at death: _____

Illnesses: _____

Cause of death: _____

Do you have any children? ( ) Yes ( ) No Ages: _____

Any health problems?

_____

_____

Have any of your blood relative had any of the following?

( ) Diabetes	( ) Breast disease	( ) Kidney disease	( ) Thyroid disease
( ) Heart attack (before age 60)	( ) Colon cancer	( ) Ovarian cancer	( ) Stroke (before age 60)
( ) Other cancer	( ) Other		

Patient Name:_____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following?

( ) Weight loss or gain	( ) Cough	( ) Yellowing eyes or skin
( ) Fever	( ) Coughing up blood	( ) Frequent urination
( ) Night sweats	( ) Wheezing	( ) Difficulty urinating
( ) Headache	( ) Loss of consciousness	( ) Blood in urine
( ) Dizziness	( ) Back pain	( ) Incontinence (accidental urination or defecation)
( ) Change in eyesight	( ) Joint swelling or pain	( ) Black or bloody bowel movements
( ) Hoarseness	( ) Chest pain/pressure/heaviness	( ) Nausea or vomiting
( ) Ringing in ears or hearing loss	( ) Stomach/abdominal pain	( ) Diarrhea
( ) Shortness of breath	( ) Loss of appetite	( ) Constipation
( ) Changes in wart, mole, or skin growth	( ) Difficulty concentrating	( ) Heartburn or indigestion
( ) Nasal congestion	( ) Difficulty swallowing	( ) Sleep problems
( ) Fatigue	( ) Loss of strength or speech	( ) Anxiety
( ) Unusual bruising or bleeding	( ) Pain in face	( ) Depression
( ) Nose bleeds	( ) Extra heart beats or racing heart	( ) Hot flashes
( ) Sexual difficulties	( ) Leg cramps	( ) Swelling of the ankles
( ) Other		

Date, location, and reason for your most recent hospital admission:

Date: _____ /_____ /_____ Location: _____

Patient Name:_____

Reason: _____

Date, location, and reason for your most recent ER visit:

Date: _____ /_____ /_____ Location: _____

Reason: _____

Date, location, and reason for your most recent doctor's office visit:

Date: _____ /_____ /_____ Location: _____

Reason: _____

Do you have a living will or durable power of attorney? ( ) Yes ( ) No

If so, please provide a copy for our records.

Would you like more information on living wills/durable power of attorney? ( ) Yes ( ) No

Do you have any ambulatory needs or limitations, such as a cane, walker, or wheelchair?

( ) Yes ( ) No

Do you have any physical disabilities? ( ) Yes ( ) No

Please describe: _____

Hearing impairment? ( ) Yes ( ) No

Vision impairment? ( ) Yes ( ) No

Date of last complete eye exam: _____ /_____ /_____ Provider: _____

Do you have trouble chewing or swallowing?

Please explain:

Patient Name:_____

_____

How many meals per day do you eat on average? _____

Do you need assistance eating meals?

Please explain: _____

Name of caregiver, if any: _____

Phone number of caregiver: _____

_____ _____ _____

Signature of patient or responsible party Relationship Date