CEDARS-SINAI®

PATIENT LABEL HERE

PATIENT HISTORY FORM

Please list any other Physicians/Providers who are treating you:

What do you hope to accomplish at your first visit?

What are your health goals?

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina
- ☐ Anorexia/Bulimia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Breast Lump
- ☐ Cancer (type)
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Colitis
- ☐ Colon Polyps
- ☐ Congenital Disorder
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug Dependency
- ☐ Emphysema
- ☐ Epilepsy (seizures)
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Hay Fever/Allergies
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Heart murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Leukemia
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Overactive Bladder
- ☐ Pace Maker
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Psoriasis
- ☐ Psychiatric Care
- ☐ Pulmonary embolism
- ☐ Rheumatic fever
- ☐ Sexually Transmitted Infection
- ☐ Stomach or peptic ulcer
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Tuberculosis
- ☐ Urinary Incontinence

Other medical conditions (please list): _____

PAST HOSPITALIZATIONS AND SURGERIES

Year	Hospitalization for?	Illness/Injuries	Surgeries

Patient's Name/DOB _____ Physician Initials _____

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MGM – Maternal Grandmother
MGF – Maternal Grandfather
PGM – Paternal Grandmother
PGF – Paternal Grandfather

FAMILY HISTORY

	Mother	Father	Sister(s)	Brother(s)	Children	MGM	MGF	PGM	PGF
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease*	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma/Emphysemia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood Disease or Clots*	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer*	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyp	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drug Dependency	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gout/Kidney Stones	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease*	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke*	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other*	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ **Check here if adopted. You may skip this page if you don't know your biological family's history.**

SPECIFIC FAMILY HISTORY

Mother	☐ Living/Age ____	☐ Deceased/Age ____	☐ Cause: _____
Father	☐ Living/Age ____	☐ Deceased/Age ____	☐ Cause: _____
How many siblings do you have?	☐ Brothers ____	☐ Sisters ____	
Are any siblings deceased?	☐ Yes	☐ No	

If YES:

Age ____	Cause _____	Age ____	Cause _____
Age ____	Cause _____	Age ____	Cause _____
Age ____	Cause _____	Age ____	Cause _____

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TOBACCO HISTORY

Have you ever used tobacco?	☐ Yes	☐ No (If NO, you may skip the remaining questions in this section)	
If YES, what form of tobacco?	☐ Cigarettes	☐ Pipe/Cigar	☐ Snuff/Chew
For how many years have you smoked in total? _____			
Over those years, what is the average number of cigarettes smoked per day? _____			
What year did you quit smoking?	☐ _____	☐ I am still smoking	
If you are still smoking, are you interested in hearing how we may be able to help you quit?	☐ Yes	☐ No	

SOCIAL HISTORY

Do you drink alcohol?	☐ Yes	☐ No	
If YES, how many drinks per week on average? _____			
Have you ever had a problem with alcohol?	☐ Yes	☐ No	
Do you use any recreational drugs?	☐ Yes	☐ No	If YES, please specify: _____
How much coffee/tea/cola do you drink per day? _____			
If you are still smoking, are you interested in hearing how we may be able to help you quit?	☐ Yes	☐ No	
How many days per week do you exercise?	☐ 0-1	☐ 2-4	☐ 5-7
	Type: _____		
Are you sexually active?	☐ Yes	☐ Not currently	☐ Never
Is/Are your sexual partner(s)	☐ Male	☐ Female	☐ Both
Do you have any concerns about your sex life?	☐ Yes	☐ No	

How would you characterize your diet?

☐ Regular/Mixed ☐ Vegan/Vegetarian ☐ Healthy Med/California Fresh ☐ No or infrequent red meat

☐ Gluten Free ☐ Low Carbohydrate ☐ Fast Food and/or Junk Food ☐ Other

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BIOGRAPHICAL/OCCUPATIONAL HISTORY

Where were you born and raised? _____

What is your highest level of education? ☐ High School ☐ Some College ☐ College Grad ☐ Advanced Degree

Marital Status ☐ Single/Never Married ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐ Partnered/Significant Other

Number of children _____

What is your current or past occupation? _____

Are you: ☐ Currently working ☐ Retired ☐ Disabled ☐ Unemployed

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CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications, and vitamins or supplements:

Name of Drug	Dose (strength & number of pills per day	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

CURRENT ALLERGIES, SENSITIVITIES, INTOLERANCES

Allergic to:	Effect:

HEALTH MAINTENANCE INFORMATION

Last Mammogram: _____ Last Pap Smear: _____ Last Colonoscopy: _____

Last Tetanus Shot: _____ Last Pneumovax/Prevnar: _____

Under 26: Have you recieved Gardisil (HPV Vaccine Series)? _____ Estimated Date: _____

Prior Hepatitis B Vaccine Series: _____ Prior Hepatitis A Vaccine Series: _____

Over 60: Have you recieved Zostovax? _____ Estimated Date: _____

Have you travelled outside the U.S. in the past two years? ☐ Yes ☐ No

When? _____ Where? _____