Palmetto Medical Group

1040 Edgewater Corp Pkwy suite 101
Indian Land SC 29707
ph: 803-548-7007 f: 803- 802-2015

Amit Shah, MD | Alexa-Gail Woolery, DNP, FNP-BC

Patient History Form

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____
Last First M

Birthdate: _____ Gender: (circle one) Male Female

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Name of Drug	Strength	Frequency Taken

Allergies to medications _____Yes _____No If yes please list below.

Name of Drug	Reaction you had

Surgery & Reason

Year	Reason

Please check yes or no

	Yes	No	How much/often & which type
Do you drink alcohol?			
Do you smoke cigarettes?			
Do you vape?			
Do you use recreational or street drugs?			

Family History- Please list below any health issues your family may have.

Family Relationship	Health Issue(s)
Mother	
Father	
Maternal grandmother	
Maternal grandfather	
Family Relationship	Health Issue(s)
Paternal grandmother	
Paternal grandfather	
Siblings	

Medical history – Please indicate conditions you are experiencing or have experienced.

___ Diabetes ___ High blood pressure ___ High cholesterol ___Hypothyroidism ___ Goiter

___Cancer (type) _____ ___ Psoriasis ___ Angina ___ Heart attack

___Heart disease ___ Stroke ___ Heart murmur ___ Pneumonia ___ Pulmonary embolism

___ Asthma ___ Emphysema ___ Epilepsy ___ Cataracts ___ Kidney disease

___ Kidney stone ___ Crohn's disease ___ Colitis ___ Anemia ___ Jaundice ___ Hepatitis

___ Stomach or peptic ulcer ___ Rheumatic fever ___ Tuberculosis ___ HIV/AIDS ___Arthritis

___ Sleeping disorder ___ADHA ___Bipolar disorder ___Depression ___Erectile dysfunction

___Migraines ___Lyme disease ___Meningitis ___Parkinson's disease ___Schizophrenia

___Sickle cell disease ___Anxiety ___Vertigo ___Pacemaker ___Port/port-a-cath

---

Mental Health – Please check yes or no

Is stress a major problem for you? ___Yes ___No Do you feel depressed? ___Yes ___No

Do you panic when stressed? ___Yes ___No Do you have a problem with your appetite? ___Yes ___No

Do you cry frequently? ___Yes ___ No Have you ever attempted suicide? ___Yes ___No

Mental Health – Please check yes or no

Have you every seriously thought about hurting yourself? ___Yes ___No

Do you have trouble sleeping? ___Yes ___No Have you ever been to a counselor? ___Yes ___No

---

Women Only

Onset age of menstruation? _____ Date of last menstruation? _____

Menstrual cycle every _____ days. Number of pregnancies? _____ Number of live births? _____

Last pap smear? _____ Last mammogram? _____ Last colonoscopy? _____

	Yes	No
Heavy periods, irregularity, spotting, pain, or discharge?		
Are you pregnant or breastfeeding?		
Have you had a D&C, hysterectomy, or Cesarean?		
Any urinary tract, bladder, or kidney infections within the last year?		
Any blood in your urine?		
Any problems with control of urination?		
Any hot flashes or sweating at night?		
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?		
Experienced any recent breast tenderness, lumps, or nipple discharge?		

Men Only

Date of last prostate and rectal exam? _____ Date of last colonoscopy? _____

	Yes	No
Do you usually get up to urinate during the night? If yes how often?		
Do you feel pain or burning with urination?		
Any blood in your urine?		
Do you feel burning discharge from penis?		
Has the force of your urination decreased?		
Have you had any kidney, bladder, or prostate infections within the last 12 months?		
Do you have any problems emptying your bladder completely?		
Any difficulty with erection or ejaculation?		
Any testicle pain or swelling?		

In the past month, have you had any of the following?

General
___ Recent weight gain, how much____
___Recent weight loss, how much ____
___Fatigue
___Weakness
___Fever

Nervous System
___Headaches
___Dizziness
___Fainting or loss of consciousness
___Numbness or tingling
___Memory loss

Muscle/Joints/Bones
___Numbness
___Joint pain
___Muscle weakness
___Joint swelling
Where? _____

Stomach & Intestines
___Nausea
___Heartburn
___Stomach pain
___Vomiting
___Yellow jaundice
___Increasing constipation
___Persistent diarrhea
___Blood in stool
___Black stools

Blood
___Anemia
___Clots

Ears
___Ringing in ears
___Loss of hearing

Skin
___Redness
___Rash
___Nodules/bumps
___Hair loss
___Color changes of hands or feet

Eyes
___Pain
___Redness
___Loss of Vision
___Double or blurred vision
____Dryness

Throat
___Frequent sore throats
___Hoarseness
___Difficulty swallowing
____Pain in jaw

Heart & Lungs
___Chest pain
___Palpitations
___Shortness of breath
___Fainting
___Swollen legs or feet
___Cough

Kidney/Urine/Bladder
___Frequent or painful urination
___Blood in urine

Women Only
___Abnormal pap smear
___Irregular periods
___Bleeding between periods
___PMS

Who may we thank for referring you to our office? _____