Patient History Form

Matthew Concannon, M.D.

Name _____ Birth Date _____

Address _____

SSN _____ Occupation _____

Home Phone _____ Work Phone _____

Marital Status ❑ Married ❑ Widowed ❑ Single ❑ Divorced

Spouse's Name/Work Number _____

Primary Care Physician _____

Doctor who referred you to see Dr. Concannon _____

Reason for visit today _____

Prior surgery you have had (include year done) _____

_____

Any medical problems (such as diabetes, heart disease, etc.) _____

_____

Is there a possibility that you could be pregnant? Yes_____No_____

Do you Smoke? Yes_____NO _____ How much?_____

Current medications (include dose and how many times a day you are taking)

_____

_____

Allergies/Reactions_____

_____

Signature:_____Date:_____

REVIEW OF SYSTEMS

Height _____ Weight _____

General:	YES	NO
Recent weight change	____	____
Poor appetite	____	____
Trouble sleeping	____	____
Fever	____	____

Eyes:		
Glasses/contacts	____	____
Loss or change of vision	____	____
Glaucoma or cataracts	____	____

Ears, Nose, Mouth and Throat:		
Hearing aids/hearing loss	____	____
Sore throat/strep throat	____	____
Nosebleeds	____	____
Recurrent ear infections	____	____

Cardiovascular:		
High blood pressure	____	____
Heart murmur	____	____
Heart attack	____	____
Irregular heartbeat	____	____

Respiratory:		
Shortness of breath	____	____
Asthma	____	____
Tuberculosis	____	____
Cough	____	____
Emphysema	____	____
COPD	____	____

Gastrointestinal:		
Ulcers	____	____
Nausea/vomiting	____	____
Constipation/diarrhea	____	____
Vomiting/passing blood	____	____
Hemorrhoids	____	____
Hepatitis	____	____
Jaundice	____	____
Cirrhosis	____	____
Gallstones	____	____

Hematologic/Lymphatic:		
Bleeding disorders	____	____
Enlarged lymph nodes	____	____

Genitourinary:	YES	NO
Problems urinating	____	____
Difficulty starting stream or dribbling	____	____
Pain, burning, frequency	____	____

Musculoskeletal:		
Abnormal growths/lumps	____	____
Joint swelling/pain	____	____
Amputation	____	____
What part? _____		

Skin:		
Psoriasis	____	____
Nonhealing, crusting	____	____
Skin cancer	____	____
Where? _____		

Breasts:		
Prior biopsy	____	____
Lumps	____	____
Bloody nipple discharge	____	____
Abnormal mammogram	____	____

Neurologic:		
Blackouts	____	____
Seizures	____	____
Headaches	____	____
Problems with speech	____	____
Confusion	____	____

Psychiatric:		
Prior counseling	____	____
Medication	____	____
Severe depression	____	____

Endocrine:		
Diabetes	____	____
Thyroid problems	____	____

Allergies/Immunologic:		
Food allergies	____	____
HIV infection	____	____