Patient History Form

Name	DOB	Address
Race/Ethnicity	Last Doctor visit/last doctor or healthcare provider	
Birthplace	Occupation	Marital status

Past Medical Problems	Past Surgeries	Allergies	Medications
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.
5.	5.	5.	5.
6.	6.	6.	6.
7.	7.	7.	7.
8.	8.	8.	8.
9.	9.	9.	9.
10.	10.	10.	10.

Do you drink alcohol? If so how much weekly	
Do you use recreational drugs? If so which ones	
Do you smoke tobacco or vape ? If so how much	
Do you drink caffeine? If so how much	
How many hours do you sleep nightly?	
Do you exercise? If so how much	
Have you received all recommended vaccines?	
Are you sexually active? Have you had an STD test ? Do you use protection ?	
Females- Last menstrual cycle, # of pregnancies, # of births , 1st day last period	

Patriot Family Medicine, 885 Patriot Drive, Unit F, Moorpark ,Ca 93021
Phone (805) 334-1371 Fax(805)-823-6201

Have you had any injuries? if so which ones, when, and describe	
Have you had a Colonoscopy? if so when/who	
Have you had a Mammogram? if so when/who	
Have you been hospitalized in the last year? if so when and why	
When was your last blood work? if so why/when	
Do you take any over the counter medications? if so which ones	
Do you have any family history of medical problems? if so please list all and specify which side of the family	

Previous Medical Symptoms (please circle all applicable)

Constipation	Depression	Allergies	Shortness of breath
Fatigue	Hallucinations	Syncope	Heart Palpitations
Dizzyness	Paranoia	Incontinence	Insomnia
Chest Pain	Diarrhea	Blurry Vision	Cancer
Loss of Balance	Anxiety	Sexual disorder/ED	Low energy

Please fill in any additional information you would like to notify the doctor about. Please feel free to discuss with the Dr.Abdulhai or caregiver

____

____

____

____

____

____

____

Patriot Family Medicine, 885 Patriot Drive, Unit F, Moorpark ,Ca 93021
Phone (805) 334-1371 Fax(805)-823-6201