David T. Nemoto M.D., P.A

Patient History Form

Today's Date: / /

Last Name	First Name	MI	Date of Birth
Marital Status: Single ☐ Divorced ☐ Married ☐ Widow/Widower ☐	**Who Lives With You?**		
Employer	**Occupation**	**What kind of work?**	
Primary Care Physician (Referring Doctor)	**Other doctors involved with your care:**		

Email: ________________________________

REVIEW OF SYSTEMS

Have you or the patient ever been diagnosed with any of the following or experiencing any of these symptoms? If yes, please check any that apply and explain in the space provided below. Is your family physician aware of any symptoms/illnesses that you have checked below? ☐ ***Yes*** ☐ ***No***

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Gastrointestinal			**Cardiac**			**Neurologic**			**Ear, Nose, & Throat**		
Diarrhea			High blood pressure			Seizures			Loose Teeth		
Constipation			Low blood pressure			Weakness			Nosebleeds		
Rectal Bleeding			Irregular heartbeat			Migraines			Deafness		
Change in BM's			Chest pain			Previous stroke			**Psychosocial**		
Weight loss			**Respiratory**			**Musculoskeletal**			Alcoholism		
Polyps			Asthma			Muscle Disease			Substance Abuse		
Irritable Bowel			Pneumonia			Arthritis			Depression		
Crohn's Disease			Bronchitis			Neck pain			Anxiety disorders		
Ulcerative Colitis			Chronic Cough			Back pain			**Breast**		
Trouble swallowing			Hoarseness			Blood Disorders			Lumps		
Nausea/Vomiting			Tracheostomy			**Skin**			Cancer		
Heartburn			**Genitourinary**			Rash			**Please list below:**		
Abdominal Pain			Kidney Disease			Bruises			**Any symptoms/diseases not listed above?**		
Hepatic			Frequent urine infection			**Ophthalmic**					
Liver Disease			**Endocrine/Metabolic**			Cataracts			**Explain:**		
Hepatitis			Diabetes			Glaucoma					
Pancreatitis			Thyroid Disorders			Blindness					

PAST HISTORY

Please explain any YES answers in detailed description in the box provided.

Question	No/Yes				
Have you ever had any surgery or been Hospitalized? **Have you had any problems with anesthesia?** **No ____ Yes _____ If yes, please list below:**	☐ No ☐ Yes	**Surgeries**	**Dates**	**Hospitalizations / ER visits**	**Dates**
Are you currently or have you ever used any Tobacco or Alcohol products?	☐ No ☐ Yes	**Alcohol: How many drinks? per day? _____per week? _____ per month? ______** **Tobacco: How many packs per day? ______ For how many years? _____________**			
Are you or have you ever used recreational /illicit drugs?	☐ No ☐ Yes	**If yes, what kind? _____________________** **For how long? ________________**			

Question	No/Yes	Medication	Dose	Times	Medication	Dose	Times
Are you currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	☐ No ☐ Yes						
Do you have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)? **Allergy:**	☐ No ☐ Yes						
****FEMALE PATIENTS**** **How many children do you have? ________** **Vaginal Delivery______ C-Section_____**							
Are you pregnant or suspect a possible pregnancy? _________________________________		**Have you had a flu shot YES/NO** **PHARMACY NAME: ______________________** **PHARMACY TELEPHONE NUMBER______________________**					

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Patient History Form

FAMILY HISTORY: ***Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:***

Condition	Mother's Side	Condition	Father's Side	Condition	Other Relatives:
Colon/ Rectal Cancer No ___ Yes __	Mother: Alive /Deceased Grandmother: Alive / Deceased Grandfather: Alive / Deceased	Colon/ Rectal Cancer No ___ Yes __	Father: Alive /Deceased Grandmother: Alive /Deceased Grandfather: Alive /Deceased	Colon/ Rectal Cancer No ___Yes ____	Children: Alive /Deceased Sibling: Alive /Deceased Brother / Sister / Uncle/ Aunt
Stomach Cancer No ___ Yes ___	Mother: Alive /Deceased Grandmother: Alive /Deceased Grandfather: Alive /Deceased	Stomach Cancer No ___ Yes ___	Father: Alive /Deceased Grandmother: Alive /Deceased Grandfather: Alive /Deceased	Stomach Cancer No ___ Yes ___	Children: Alive /Deceased Sibling: Alive /Deceased Brother / Sister / Uncle/ Aunt
Breast Cancer No ___ Yes ___	Mother: Alive / Deceased Grandmother: Alive / Deceased Grandfather: Alive / Deceased	Breast Cancer No ___ Yes ___	Father: Alive /Deceased Grandmother: Alive /Deceased Grandfather: Alive /Deceased	Breast Cancer No ___ Yes ___	Children: Alive /Deceased Sibling: Alive /Deceased Brother / Sister / Uncle/ Aunt

OTHER HISTORY:

Do you exercise?	Are you following any particular diet?	Have you traveled outside the US in past 6 months?
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

To help Dr. Nemoto determine the cause of your symptoms it is vital that you help provide any test results from the past which may aide him in helping determine what is wrong with you.

List all Doctors you see or have seen in the past.
1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

Have any Doctors ordered any blood or urine test? If so which doctor (s)?, when?
1. ____
2. ____
3. ____
4. ____

Have you had and X-rays, Ultrasounds, Ct Scans or MRI's? If so, when? And with which Doctor?
1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

I as patient of Dr. Nemoto have completed this form to the best of my knowledge and I am aware that I will have to provide such information to help with my medical care.

____ ____________________________________

Person Completing This Form/Relationship to Patient **Reviewed by Provider Date**