Laura Johnson, NP, PC
FAMILY PRACTICE NURSE PRACTITIONER
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Today's Date:_____ Patient's Name: _____ DOB: _____

PAST MEDICAL HISTORY

Please mark any of the following that you have or have had in the past:

Adrenal Dysfunction	☐ Yes	☐ No
Amyotrophic Lateral Sclerosis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Autoimmune Disease	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Cerebrovascular Accident (Stroke)	☐ Yes	☐ No
Claudication	☐ Yes	☐ No
Congenital Heart Defects	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No
Endocarditis	☐ Yes	☐ No
End Stage Renal Disease	☐ Yes	☐ No
Esophageal Dysfunction	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No
GERD (reflux problems)	☐ Yes	☐ No
Heart or Valve Defects	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
HIV or AIDS	☐ Yes	☐ No
Hyperthyroidism	☐ Yes	☐ No
Irregular Heart Rhythm	☐ Yes	☐ No
Kidney Failure or Dysfunction	☐ Yes	☐ No
Malignancy – please describe:	☐ Yes	☐ No

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Myocardial Infarction (Heart Attack)	☐ Yes	☐ No
Obstructive Sleep Apnea	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Pancreatitis	☐ Yes	☐ No
Personality Disorder	☐ Yes	☐ No
Polycystic Ovarian Syndrome	☐ Yes	☐ No
Pulmonary Fibrosis	☐ Yes	☐ No
Recurrent Infections	☐ Yes	☐ No
Sarcoidosis	☐ Yes	☐ No
Scleroderma	☐ Yes	☐ No
Seizure Disorder	☐ Yes	☐ No
Sjogren's Syndrome	☐ Yes	☐ No
Thalassermia	☐ Yes	☐ No
Thrombophilia	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Vasculitis	☐ Yes	☐ No
Vocal Cord Dysfunction/Paralysis	☐ Yes	☐ No

Alzheimer's	☐ Yes	☐ No
Anorexia or Bulimia	☐ Yes	☐ No
Arteriosus Malformations (AVMs)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Chemotherapy – when?	☐ Yes	☐ No

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Clotting Disorder	☐ Yes	☐ No
Coronary Artery Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Eclampsia or Pre-eclampsia	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No
Erectile Dysfunction	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Gastritis or Gastric Ulcers	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hermochiromatosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Inflammatory Bowel Disease	☐ Yes	☐ No
Kyphosis	☐ Yes	☐ No
Liver Dysfunction	☐ Yes	☐ No
Mania	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No
Narcolepsy	☐ Yes	☐ No
Organ Transplant – if yes, describe:	☐ Yes	☐ No

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Peripheral Artery Disease	☐ Yes	☐ No
Pituitary Dysfunction	☐ Yes	☐ No
Pulmonary Artery Hypertension	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No
Restless Leg Syndrome	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Scoliosis	☐ Yes	☐ No
Sickle Cell	☐ Yes	☐ No
Skin Disorders (Psoriasis, Acne)	☐ Yes	☐ No
Thrombocytopenia	☐ Yes	☐ No
Transfusions	☐ Yes	☐ No
Urinary Retention or Urgency	☐ Yes	☐ No
Visual Defects	☐ Yes	☐ No