Dr. Julian De Bruyn Kops

208-522-6106

Patient History Form

Your Name: _____ Date of Birth: _____

Today's Date: _____

Social Security Number: ____-___-_____ E-mail Address: _____

What is the reason for your visit today? _____
_____

Medications:

Prescription/non-prescription Medications	Dose	How often taken

Past Medical History:

Please list other diseases from which you currently suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the past:

Allergies or Adverse Drug Reactions? Please list the drug and type of reaction.

Women:

Have you had a mammogram? No ____ Yes ____ If yes, when? _____

Have you gone through menopause? No ____ Yes ____ If yes, what year did it start? _____

How many pregnancies have you had in total? _____

Any miscarriages? No ____ Yes ____ If yes, how many? ____

Have you had a C-Section? No ____ Yes ____ If yes, when? ____

Have you had a Pap smear? No ____ Yes ____ If yes, when was your last? ____

Are you taking Birth Control? No ____ Yes ____ If yes, what kind? _____

Surgeries/Operations? Please list any surgeries, reasons for the surgery, and date of surgery.

Hospitalizations? Please list any hospitalizations within the past 4 years.

Family History. Place an "X" in appropriate boxes to identify all illness/conditions in your blood relatives

Illness/Condition	Family Member								
	Maternal Grandma or Grandpa? (specify)	Paternal Grandma or Grandpa? (specify)	Father	Mother	Brother	Sister	Son	Daughter	Other
Colon/Rectal cancer									
Other cancer (specify)									
Heart disease									
Diabetes									
High blood pressure									
Liver disease									
High cholesterol									
Alcohol abuse									
Drug abuse									
Depression/Anxiety (specify)									
Psychiatric illness (specify)									
Genetic (inherited) disorder (specify)									
Alive									
Deceased									
Other									

Habits: Do you smoke: No____ Yes____ If yes, how often do you smoke? _____

If yes, how many cigarettes per day? _____

If yes, how soon after you wake up do you smoke your first cigarette?

_____

If yes, are you interested in quitting?

_____

If you have quit, how long ago? _____

Do you use alcohol? No____ Yes____ If yes, how often do you drink? _____

If yes, how many drinks per day? _____

If you have quit, how long ago? _____

Do family and friends worry about your alcohol intake? _____

Do you drink caffeine? No ____ Yes____ If yes, how often do you drink it? _____

Do you exercise? No ____ Yes____ If yes, how often? _____

What is your marital status? Single____ Married____ Separated____ Divorced____ Widowed____

What is your occupation? _____

Symptom Review

Gastrointestinal

- ☐ Poor appetite
- ☐ Abdominal pain
- ☐ Indigestion
- ☐ Trouble swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Nausea or vomiting
- ☐ Rectal bleeding or blood in stools
- ☐ History of liver disease or abdominal liver tests

Cardiovascular

- ☐ Chest pain
- ☐ History of angina or heart attack
- ☐ History of high blood pressure
- ☐ History of irregular heart beat
- ☐ History of poor circulation

Pulmonary/lungs

- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Asthma or wheezing

Muscle/joint/bone

- ☐ Swelling of ankles or legs

Pain, weakness or numbness in…

- ☐ Arms or hands
- ☐ Back or hips
- ☐ Legs or feet
- ☐ Neck or shoulders

Neurologic

- ☐ History of stroke
- ☐ Blackouts or loss of consciousness

General

- ☐ Weight gain/loss of 10+ lbs. during last 6 months
- ☐ Poor sleep
- ☐ Fever
- ☐ Headache
- ☐ Depression

Eyes, ears, nose, throat

- ☐ Blurred vision
- ☐ Other change in vision
- ☐ History of glaucoma or cataracts
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Hoarseness

Genitourinary

- ☐ Frequent or painful urination
- ☐ Blood in urine

Skin

- ☐ Itching
- ☐ Easy bruising
- ☐ Change in moles

Endocrine

- ☐ History of diabetes
- ☐ History of thyroid disease
- ☐ Change in tolerance to hot/cold weather
- ☐ Excessive thirst

Women Only

- ☐ Abnormal Pap smear
- ☐ Bleeding between periods

Men Only

- ☐ PSA

Immunizations: If YES, give approximate year given

Pneumococcal	No_____ Yes_____
Hepatitis A	No_____ Yes_____
Hepatitis B	No_____ Yes_____
Tetanus	No _____Yes_____
Flu Shot	No _____Yes_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, Birth day: _____, hereby authorize to have my medical records released at your earliest convenience to:

Julian de Bruyn Kops, M.D., P.A.

2065 E. 17th Street, Suite C

Idaho Falls, ID 83404

Phone: (208) 522-6106

Fax: (208) 522-6142

Comments:

_____
_____
_____
_____

Signature: _____ Date: _____