

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office: Information contained here will not be released to anyone without your authorization to do so.

Today's Date: _____ **Last Physical Exam:** _____ **Referring Physician:** _____

Last Name: _____ **First Name:** _____ **Middle:** _____

Social Security No: _____ **Date of Birth:** _____ **Age:** _____

Chief Complaint:

What is the main reason for your visit today: (Describe your problem in detail).

History of Present Illness

Please answer the following questions:

Location of Problem:

How long does the problem last:

30 minutes 1 hour
It is always there

On a Scale of 1 – 10, with 10 being the most Severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

Is the problem constant or variable?

Does anything help or make the problem worse?

Moving around Standing up

Lying on my side

When did you first notice the problem?

2 days ago 2 weeks ago
1 month ago

Is anything else occurring at the same time?
Yes No If yes, please explain.

Past Medical and Social History

List Past Medical Problems:

_____	_____	_____
_____	_____	_____
_____	_____	_____

List Prior Surgeries:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications:

Medication Allergies:

General Allergies:

Family Medical Problems:

Smoke:

Yes No How much _____

Drink:

Yes No How much _____