

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

Is the problem constant or variable?

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

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 _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided.

<p>Constitutional Symptoms</p> <p>Fever Y N</p> <p>Chills Y N</p> <p>Headache Y N</p> <p>Other Y N</p> <p>Eyes</p> <p>Blurred vision Y N</p> <p>Double vision Y N</p> <p>Pain Y N</p> <p>Other Y N</p> <p>Allergic/Immunologic</p> <p>Hay fever Y N</p> <p>Drug allergies Y N</p> <p>Other Y N</p> <p>Neurological</p> <p>Tremors Y N</p> <p>Dizzy spells Y N</p> <p>Numbness/tingling Y N</p> <p>Other Y N</p> <p>Endocrine</p> <p>Excessive thirst Y N</p> <p>Too hot/cold Y N</p> <p>Tired/sluggish Y N</p> <p>Other Y N</p> <p>Gastrointestinal</p> <p>Abdominal pain Y N</p> <p>Nausea/vomiting Y N</p> <p>Indigestion/heartburn Y N</p> <p>Other Y N</p> <p>Cardiovascular</p> <p>Chest Pain Y N</p> <p>Varicose veins Y N</p> <p>High blood pressure Y N</p> <p>Other Y N</p>	<p>Integumentary</p> <p>Skin rash Y N</p> <p>Boils Y N</p> <p>Persistent itch Y N</p> <p>Other Y N</p> <p>Muskuloskeletal</p> <p>Joint pain Y N</p> <p>Neck pain Y N</p> <p>Back pain Y N</p> <p>Other Y N</p> <p>Ear/Nose/Throat/Mouth</p> <p>Ear infection Y N</p> <p>Sore throat Y N</p> <p>Sinus problems Y N</p> <p>Other Y N</p> <p>Genitourinary</p> <p>Urine retention Y N</p> <p>Painful urination Y N</p> <p>Urinary frequency Y N</p> <p>Other Y N</p> <p>Respiratory</p> <p>Wheezing Y N</p> <p>Frequent cough Y N</p> <p>Shortness of breath Y N</p> <p>Other Y N</p> <p>Hematologic/Lymphatic</p> <p>Swollen glands Y N</p> <p>Blood clotting problem Y N</p> <p>Other Y N</p> <p>Psychologic</p> <p>Are you generally satisfied with your life? Y N</p> <p>Do you feel severely depressed? Y N</p> <p>Have you considered suicide? Y N</p> <p>Other Y N</p>
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Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____
