

Comprehensive Patient History Form

Patient Name: _____ Age: _____

Appt. Date: _____

Current Weight _____ Best Weight _____ Height _____

Describe your main problem _____

Where is your problem located? _____ How long have you had this problem? _____

How severe is your problem? _____

When does this problem occur? _____

List all other symptoms _____

Please do not write in this space

Medication Allergies

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

Have you ever had the following?

Diabetes.....	yes	no
Hypertension.....	yes	no
Cancer.....	yes	no
Stroke.....	yes	no
Heart trouble.....	yes	no
Convulsions.....	yes	no
Bleeding tendency.....	yes	no
Hepatitis.....	yes	no
HIV or Exposure to.....	yes	no
Lung Problems.....	yes	no
Sleep Apnea.....	yes	no

List Surgeries/ Past & Present Illnesses / Serious Injuries

When?

List Medications/Herbs you are currently taking and Dosage:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

Patient Social History

Occupation _____

Marital Status: Single Married Separated Divorced Widowed

Use of alcohol: Never Rarely Moderate Daily _____

Use of tobacco: Never Previously but quit Current packs per day _____

Use of Drugs: Never Type/Frequency _____

Family Medical History

	<u>Age</u>	<u>Diseases</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

PLEASE ANSWER ALL QUESTIONS

HAVE YOU HAD ANY OF THE FOLLOWING DURING THE PAST ONE-YEAR?

CONSTITUTIONAL

Recent weight change..... No Yes
 Fever..... No Yes
 Fatigue..... No Yes
 Headaches..... No Yes

EYES

Eye disease or injury..... No Yes
 Wear glasses/contact lens..... No Yes
 Blurred or double vision..... No Yes

ENT

Hearing loss..... No Yes
 Nose bleeds..... No Yes
 Mouth sores..... No Yes
 Bleeding gums..... No Yes
 Swollen glands in neck..... No Yes

CARDIOVASCULAR

Heart trouble..... No Yes
 Chest pains..... No Yes
 Swelling of feet, ankles or hands..... No Yes
 History of Blood Clots (DVT)..... No Yes

RESPIRATORY

Frequent coughing..... No Yes
 Spitting up blood..... No Yes
 Shortness of breath..... No Yes
 Asthma or wheezing..... No Yes

GASTROINTESTINAL

Loss of appetite..... No Yes
 Change in bowel movements..... No Yes
 Nausea or vomiting..... No Yes
 Frequent diarrhea..... No Yes
 Painful bowel movements or constipation..... No Yes
 Blood in stool..... No Yes
 Stomach pain..... No Yes

GENITOURINARY

Frequent urination..... No Yes
 Burning or painful urination..... No Yes
 Blood in urine..... No Yes
 Incontinence or dribbling..... No Yes
 Kidney stones..... No Yes
 Female – vaginal discharge..... No Yes
 Female – # pregnancies _____ # miscarriages _____
 Female – date of last pap smear _____
 Female – findings of last pap smear Normal Abnormal

MUSCULOSKELETAL

Joint stiffness or swelling..... No Yes
 Weakness of muscles or joints..... No Yes
 Muscle pain or cramps..... No Yes
 Back pain..... No Yes
 Difficulty in walking..... No Yes

SKIN

Rash or itching..... No Yes
 Change in moles or skin lesions..... No Yes
 Varicose veins..... No Yes
 Breast pain..... No Yes
 Breast lump..... No Yes
 Breast discharge..... No Yes

NEUROLOGICAL

Frequent or recurring headaches..... No Yes
 Convulsions or seizures..... No Yes
 Numbness or tingling sensations..... No Yes
 Tremors..... No Yes
 Paralysis..... No Yes
 Stroke..... No Yes
 Head injury..... No Yes

PSYCHIATRIC

Memory loss or confusion..... No Yes
 Nervousness..... No Yes
 Depression..... No Yes

ENDOCRINE

Thyroid disease..... No Yes
 Diabetes..... No Yes

HEMATOLOGIC/LYMPHATIC

Easily bruise or bleed..... No Yes
 Anemia..... No Yes
 Phlebitis..... No Yes
 Enlarged glands..... No Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reactions to:
 Penicillin or other antibiotics..... No Yes
 Morphine, Demerol or other narcotics.. No Yes
 Novocaine or other anesthetics..... No Yes
 Aspirin or other pain remedies..... No Yes
 Tetanus antitoxin or other serums..... No Yes
 Iodine, methiolate or other antiseptic... No Yes
 Other drugs/medications _____
 Known allergy to Latex _____
 Known food allergies _____

Patient Signature: _____

Physician Signature: _____

Appt. Date: _____