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 written authorization to do so.

Today's date _____ Primary care provider _____

Last name _____ First name _____ Middle _____

Age _____ Birthdate _____ Height _____ Weight _____

Explain in detail the ***main*** reason for your visit today? _____

_____

HISTORY OF PRESENT ILLNESS

Location of the problem
abdomen back genitals
other _____

_____

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

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
other _____

Does any thing help or make the problem worse?
moving around standing up lying on side
other _____

How long does the problem last?
30 minutes 1 hour it is always there
other _____

Is anything else occurring at the same time?
yes no if yes, please explain:
nausea rash headaches
other _____

Is the problem constant or variable?
Dull then sharp very sharp then leaves always there
Other _____

Does the problem interfere with your normal functions?
yes no if yes, please explain:
_____

PAST MEDICAL HISTORY

Illnesses: Have you had any of the following problems?

_____chest pain
_____heart attack (M.I.)
_____lung disease
_____blood clot (legs lungs)
_____stroke (CVA)
_____hepatitis
_____high blood pressure
_____stomach ulcer disease
_____abnormal bleeding or bruising
_____glaucoma
_____abnormal heart rhythm
_____shortness of breath
_____diabetes
_____seizure
_____HIV / AIDS
_____other _____

_____pacemaker If yes, please provide the type and company number (check with cardiologist if necessary) _____

_____

Surgery: List type and approximate date

Date	Surgery	Date	Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications: list name, dose and frequency of all medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Preferred Pharmacy _____ **Location** _____

Do you take aspirin? _____ Do you take supplements? _____

Allergies: list all medications that you are allergic to:

_____

_____

FAMILY & SOCIAL HISTORY

List all serious illnesses in your *immediate* family. Example: diabetes, tuberculosis, breast cancer, heart disease, prostate cancer, kidney disease

Disease	Relationship	Disease	Relationship

Do you smoke? yes no If yes, how much? _____ Have you smoked in the past? yes no

Do you drink alcoholic beverages? yes no If yes, how often? _____

Review of Systems:

If you are ***currently*** experiencing any of the following symptoms please circle "yes". Anything not circled will be considered "no".

General symptoms

Yes No Fever
Yes No Chills
Yes No Headache
Other_____

Eyes

Yes No Blurred vision
Yes No Double vision
Yes No Pain
Other_____

Allergic / Immunologic

Yes No Hay fever
Yes No Drug allergies
Other_____

Neurological

Yes No Tremors
Yes No Dizzy spells
Yes No Numbness / tingling
Other_____

Endocrine

Yes No Excessive thirst
Yes No Too hot / cold
Yes No Tired / sluggish
Other_____

Gastrointestinal

Yes No Abdominal pain
Yes No Nausea / vomiting
Yes No Indigestion / heartburn
Other_____

Cardiovascular

Yes No Chest pain
Yes No Varicose veins
Yes No High blood pressure
Other_____

Integumentary

Yes No Skin rash
Yes No Boils
Yes No Persistent itch
Other_____

Musculoskeletal

Yes No Joint pain
Yes No Neck pain
Yes No Back pain
Other_____

Ear / Nose / Throat / Mouth

Yes No Ear infection
Yes No Sore throat
Yes No Sinus problems
Other_____

Genitourinary

Yes No Urine retention
Yes No Painful urination
Yes No Urinary frequency
Other_____

Respiratory

Yes No Wheezing
Yes No Frequent cough
Yes No Shortness of breath
Other_____

Hematologic / lymphatic

Yes No Swollen glands
Yes No Blood clotting problem
Other_____

Psychologic

Yes No Are you generally satisfied with your life?
Yes No Do you feel severely depressed?
Yes No Have you considered suicide?
Other_____

I believe that the above information is correct to the best of my knowledge.
Patient Signature_____Date _____

I have reviewed the above information with the patient. _____