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_____/_____/_____ **DATE OF LAST PHYSICAL EXAM**_____/_____/_____

LAST NAME_____ **FIRST NAME**_____ **MIDDLE**_____

Social Security No. _____ **DATE OF BIRTH**_____/_____/_____

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 the problem

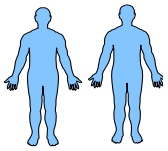
Abdomen Back Leg

Other_____

_____

_____

Front **Back**



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 anything help or make the problem worse?

Moving around Standing Up Lying on my 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_____

_____

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery **Date**

_____

_____

_____

Do you smoke? Y N

If yes, how much? _____

Do you drink? Y N

If yes, how much? _____

Are you on any medications? Y N (If yes, list all.)

_____ _____

_____ _____

Are you on a special diet? Y N (If yes, please explain)

_____

Do you have allergies? Y N (If yes, Please explain.)

_____

_____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5

(OVER)

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Please explain any Yes answers here.

Constitutional Symptoms

Fever	Y	N	Headache	Y	N
Chills	Y	N	Other _____		

Eyes

Blurred Vision	Y	N	Double Vision	Y	N
Pain	Y	N	Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N	Sinus problems	Y	N
Sore throat	Y	N	Other _____		

Respiratory

Wheezing	Y	N	Shortness of breath	Y	N
Frequent cough	Y	N	Other _____		

Gastrointestinal

Abdominal Pain	Y	N	Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N	Other _____		

Genitourinary

Urine retention	Y	N	Urinary frequency	Y	N
Painful urination	Y	N	Other _____		

Musculoskeletal

Joint pain	Y	N	Back pain	Y	N
Neck pain	Y	N	Other _____		

Integumentary

Skin rash	Y	N	Boils	Y	N
Persistent itching	Y	N	Other _____		

Neurological

Tremors	Y	N	Numbness/tingling	Y	N
Dizzy spells	Y	N	Other _____		

Endocrine

Excessive thirst	Y	N	Tired/sluggish	Y	N
Too hot/cold	Y	N	Other _____		

Cardiovascular

Chest Pains	Y	N	Varicose veins	Y	N
High blood Pressure	Y	N	Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N	Blood clotting problem	Y	N

Other _____

Allergic/Immunologic

Hay Fever	Y	N	Drug allergies	Y	N

Other _____

Psychologic

Are you generally satisfied with you life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other _____

Physician use only: (Comments/Notes)

#Answer Service	Level of
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____ Signature: _____ Date: _____/_____/_____