

# 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: \_\_\_\_\_

NAME OF PHYSICIAN REQUESTING THIS EVALUATION \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

## CHIEF COMPLAINT

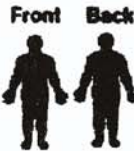
What is the main reason for your visit today? (Describe your problem in detail)

## History of Present Illness

Please answer the following questions

### Location of the problem

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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

## Past Medical, Family & Social History

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Illness or Surgery Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you on a special diet? Yes No. (If Yes, please explain)

\_\_\_\_\_  
\_\_\_\_\_

Do you have allergies? Yes No (If Yes, please explain)

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke?  Yes  No

If yes, how much? \_\_\_\_\_

Do you drink?  Yes  No

If yes, how much? \_\_\_\_\_

Do you exercise regularly?  Yes  No

If yes, how much? \_\_\_\_\_

Are you currently taking any medication? If Yes, please list all.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Review of Systems

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

## Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

## Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

## Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other _____		

## Neurological

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

## Endocrine

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

## Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

## Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other _____		

Physician use only: (Comments/Notes)

## Integumentary

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

## Musculoskeletal

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

## Ear/Nose/Throat/Mouth

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

## Genitourinary

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

## Respiratory

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

## Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

## Psychologic

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

Physician \_\_\_\_\_  
 Physician \_\_\_\_\_  
 Physician \_\_\_\_\_  
 Physician \_\_\_\_\_  
 Physician \_\_\_\_\_  
 Physician \_\_\_\_\_

Date \_\_\_\_\_  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_