

PATIENT HISTORY FORM

TODAY'S DATE _____/_____/_____


LAST NAME _____

FIRST NAME: _____

DATE OF BIRTH: _____

Chief Complaint or the main reason for your visit today? (Describe your in detail)

History of Present Illness (Please answer the following questions completely or write N/A)

<p>Location of the problem Abdomen Back Leg Other _____ _____ _____</p>	<p>Front Back</p> 	<p>Is anything else occurring at the same time? YES NO If yes, please explain. Nausea Rash Headaches Other _____</p>
<p>AT ITS WORST.....On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?</p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10</p>	<p>Does anything make the problem better?</p> <p>_____</p> <hr/> <p>Does anything make the problem worse?</p> <p>_____</p>	
<p>When did you first notice the problem? 2 days ago 2 weeks ago 1 month ago</p>	<p>Does the problem interfere with your normal functions? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain</p>	
<p>How long does the problems last? _____</p> <p>Is the problem constant or variable? Dull then Sharp Very sharp then leaves Always there Other _____</p>		

MD ONLY: (COMMENTS/ NOTES)	# ANSWERS	LEVEL
	1-3	1 OR 2
	4 +	3-5

Past Medical, Family & Social History

(List all serious illnesses in your immediate family. Please fill in every box with information or N/A)

DISEASE	PARENTS	BROTHERS /SISTERS	CHILDREN	DISEASE	PARENTS	BROTHER/ SISTERS	CHILDREN	
DIABETES				BLEEDING				Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____ Do you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____ Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____ Married: _____ # of Children: _____
CANCER				KIDNEY PROBLEM				
HEART DISEASE				OTHER				
HIGH BLOOD PRESSURE				OTHER				

<p>Past Illness and Dates</p> <table style="width: 100%;"> <tr> <th style="width: 70%;">Illnesses</th> <th style="width: 30%;">Date</th> </tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </table>	Illnesses	Date	_____	_____	_____	_____	_____	_____	_____	_____	<p>Past Surgeries and Dates</p> <table style="width: 100%;"> <tr> <th style="width: 70%;">Surgeries</th> <th style="width: 30%;">Date</th> </tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </table>	Surgeries	Date	_____	_____	_____	_____	_____	_____	_____	_____	<p>Comments:</p> <p>_____</p> <p>_____</p>
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MD ONLY: (COMMENTS/ NOTES)	# ANSWERS	LEVEL
	0	1 or 2
	1-2	3
	3	4 or 5

Review of Systems

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

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 _____		

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 _____		

Patient/family signature: _____ Date: _____

Physician use only: Comments/Notes 	<table border="0" style="font-size: small;"> <tr> <td># ANSWER</td> <td>LEVEL</td> </tr> <tr> <td>0-1</td> <td>1 OR 2</td> </tr> <tr> <td>2-9</td> <td>3</td> </tr> <tr> <td>10+</td> <td>4 OR 5</td> </tr> </table> <p style="text-align: center; font-size: x-small;">Modified 5/6/02</p>	# ANSWER	LEVEL	0-1	1 OR 2	2-9	3	10+	4 OR 5
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10+	4 OR 5								

XX MD SIGNATURE: _____ **Date:** _____

