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 occuring 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 occured.

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 in space provided

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 problems 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 use only: (Comments/Notes)

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

Physician: _____ Date:____/____/____

REORDER # 0804756