# PATIENT HISTORY FORM

Print 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)

_____

_____

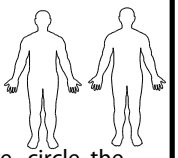
_____

## History of Present Illness

Please answer the following questions

Location of the problem

Front Back



Abdomen Back Leg

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 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.

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 _____

Please explain any Yes answers here.

Physician use only: (Comments/Notes)

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

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